

NATIONAL ASSOCIATION FOR MENTAL HEALTH

Report of the Proceedings
of a
CONFERENCE
on
MENTAL HEALTH

Held at St. Pancras Town Hall, London, N.W.1

14th-15th NOVEMBER, 1946

IMH

HJ/42(a)

FRIDAY, NOVEMBER 15th

MORNING SESSION, 10.30 TO 1.0

Chairman: **Rev. John H. Litten** (Principal, National Children's Home).

Subjects:

- (a) THE CARE OF THE HOMELESS CHILD.
- (b) JUVENILE DELINQUENCY.

Speakers:

Lucy G. Fildes, B.A., Ph.D. (Chief Educational Psychologist, London Child Guidance Training Centre).

Margery Fry, M.A., J.P.

DISCUSSION

FRIDAY, NOVEMBER 15th

AFTERNOON SESSION, 2.30 TO 5.0

Chairman: **The Rt. Hon. R. A. Butler, M.P.**

For part of this Session the Chair was taken by

The Earl of Feversham, D.S.O., D.L., J.P.

Subjects:

- (a) THE INTEGRATION OF THE PSYCHOLOGICAL SERVICES UNDER THE NEW EDUCATION ACT (1944).
- (b) THE FUTURE ROLE OF THE CHILD GUIDANCE CLINIC IN EDUCATION AND OTHER SERVICES.

Speakers:

Norah Gibbs, M.A. (Educational Psychologist, National Association for Mental Health).

John Bowlby, M.D. (Psychiatrist in charge Child Guidance Unit, The Tavistock Clinic, London).

DISCUSSION.

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THURSDAY, NOVEMBER 14th
MORNING SESSION

Chairman:

J. M. Macintosh, M.A., M.D., F.R.C.P.

(Dean and Professor of Public Health, London School of Hygiene and Tropical Medicine, University of London)

INAUGURAL ADDRESS:

Sir Otto Niemeyer, G.B.E., K.C.B.

(Chairman, Provisional National Council for Mental Health)

When I welcomed members to the last Conference on Mental Health at Caxton Hall in October, 1943, it was as Chairman of the Provisional National Council. In welcoming you here to-day, I want to underline two great changes since that last Conference in 1943. In the first place we have out-grown Caxton Hall. There has been such a demand for tickets for this Conference that we have had to provide larger accommodation. I take that as an eloquent and cheering indication of the growing interest in our work. In the second place, after to-day, you will hear no more of the Provisional Council. I must remind you, therefore, that to-day is in one sense a Burial Service.

Let me now recall to your memories some of the recent history of the Mental Health organisations. The Feversham Report in 1939 recommended the establishment of a new central body in England which was to co-ordinate and amalgamate the voluntary Mental Health organisations of the country. The war delayed the technical arrangements for that amalgamation, although many practical steps towards some measure of co-ordination were taken, in the first place in the form of the Mental Health Emergency Committee and, in the second place, in its successor, the Provisional National Council. When I was asked to become chairman of that organisation, it was with a view to a closer amalgamation.

I am glad therefore to be able to tell you to-day that, after prolonged negotiations and discussions with all concerned, the necessary licence has now been received from the Board of Trade for the founding of a new National Association, in which will be amalgamated the Central Association for Mental Welfare, the Child Guidance Council and the National Council for Mental Hygiene. All the formal steps for these amalgamations have now been taken and I hope that shortly after Christmas the new Association for Mental Health will be able to meet and elect its own officers and

committees. That, by contrast with to-day, will be the Christening Service.

Every amalgamation of this sort involves some sacrifice of individual interests, but we confidently believe that the resulting unity will more than repay the loss and that the new Association will be in a strong position to carry on with even greater activity all the essential functions of each of its three constituent bodies. The appointments already in existence of a Medical Director and of a full-time General Secretary are an important addition to the organisation of our work.

I want particularly to enlist your active support for this National Association for Mental Health, because it is on individual support and individual interest that our work depends.

Our aims and objects remain what they have always been—the awakening among the general public of a realisation of the importance of mental health; the establishment of a service of Mental Health, particularly for young children, and all which is involved in the provision of child guidance clinics and in the training of adults working there; the provision of training facilities for all groups of professional mental health workers; the provision of information on Mental Health facilities; the encouragement of Mental Health research; and the calling of Conferences, national or international, on all these subjects. For all these things there is to-day an increasing demand. To take but one example, the After-Care Scheme for psychiatric cases discharged from the Services, an entirely new function. By the end of this year, this scheme will have accepted its 10,000th patient, and it now employs over 100 workers of various types.

We all know of the increasing need for workers in the general Mental Health field and the difficulties of providing for their training. We all know the difficulties of finding places in hospitals and homes, particularly now that the special homes for evacuated children which existed during the war are no longer available. We are, in fact, ourselves, hoping to open one or more homes for such children. Again, we have at the present time 9 agricultural hostels. These have had a particularly successful development and already over 935 defectives have been successfully employed. We hope shortly also to open a special convalescent home for epileptics.

Plans are now being made, after the gap caused by the war, to organise, in co-operation with other mental health bodies, a World Congress on Mental Health in London in August, 1948.

There is no end to the scope of our activities, but they all depend on the support which the National Association itself receives.

There is one particular development which we should like to see, namely, the formation of local branches of this National Association, local branches which would be locally responsible in their own areas in co-operation with our own regional representatives. One such branch has been established recently in Birmingham, and we hope that many other centres will follow this lead.

We believe that the successful foundation of a new National Association for Mental Health comes at a moment when all the omens point to large possibilities for extending and popularising its work. Now, therefore, is the moment for all who are interested in this extensive field of activity to support the new Association. I confidently appeal to you to do so and to enlist the help of others.

The Chairman: I feel that we all owe Sir Otto Niemeyer, from the Mental Health point of view, a debt of gratitude for the tremendous amount of work he has undertaken during the war and in relation to the difficult period of amalgamation.

I suppose I have the privilege to-day to be Chairman, partly because I undertook certain functions in the antenatal period of this Council, and also I had the privilege of taking the first course for school medical officers, organised by the Central Association for Mental Welfare. I am very glad to say that we still have with us active and vigorous life members of a still older group who belonged to the vintage of 1913 and who fought the battles for the great Mental Deficiency Act of that year.

We have a very profitable and full morning. The discussion, as you will see from the agenda, ranges widely but is especially associated with the application to civilian life of certain important findings under war conditions. I should like to point out that this Conference has the enormous advantage of allowing us to hear other people's views and to offer our own views to other people. It also enables us to meet and talk together.

We are especially interested in learning the lessons of the war, and no one is better able to speak on the application to civilian population of wartime experiences in neurosis and backwardness than Dr. J. R. Rees, a very old friend of the soldier and a special friend of the young officer. He has taken a large part in helping these and in helping the Army, especially where there have been difficulties of adjustment to army life; and the same experiences can usefully be adapted to civilian life.

Experiences of Neurosis and Backwardness in the War-Time Army

Can they help with Civilian Problems?

J. R. Rees, C.B.E., M.D., F.R.C.P.

*(Physician, The Tavistock Clinic, London; Hon.
Consulting Psychiatrist to the Army)*

In this phase of planning and resettlement we are faced with a multitude of problems and possibilities. In no field is the urgency greater than in that of Mental Health, and like all of you, I therefore welcome this first Post-War Conference on the subject.

Those who have studied the development and the general trends of interest in Mental Health in this country will certainly be aware that as a result of the 1914-18 war there was a considerable awakening of public conscience and of medical interest in the problems of emotional disorder and its proper treatment. The vividness of war experience and the tremendous challenge that was presented by that wave of battle neurosis which began in the later stages of the Somme fighting, fired the curiosity and the humanity of many people. As a result, out-patient clinics were set up, new facilities of all kinds began to be developed, and some serious attempt to provide psychotherapy for individuals, irrespective of their financial status, became evident. War is not wholly destructive, and some long term results can be achieved if we are alive to the lessons than war-time experience provides.

The recent war has given us the opportunity of re-learning or confirming a good deal that was evident twenty-five years previously. We have improved to some extent our understanding of the nature and treatment of the acute war neuroses, although in fact little that is completely new has emerged in that particular field. The emphasis in this war, for a variety of reasons, has been more on prophylactic psychiatry and upon teamwork with our colleagues trained in psychology and sociology. We have been more conscious of our shortage of man power; the technical methods and weapons of warfare have become much more complex and demanding, and above all there has been a general awareness that the human factor in any great concern such as the Services in war time, is what matters most.

A great deal of thought therefore has been given, not

without result, to the better understanding and management of men, to the building and maintenance of good morale, and indeed to a great variety of measures to help promote efficiency and good health, physical and mental.

There are obvious difficulties in any attempt to compare war time procedures in a Service such as the Army with the peace time methods of civilian life. Large groups of men and women under discipline, fired to a great extent by a common purpose, selected to some extent before their admission to the Services, must obviously conduce to easier management than the freer, more heterogeneous groups that we meet in industry and in the community generally. It is hardly necessary that any further warning should be given on a point of that sort, but there remains the obvious fact that principles that have been worked out, and any experimental work that has been done in the Services can be of interest to those of us who are concerned with the problems of civilian life at present. Experiments leading to adaptation of such methods must certainly be considered, and it would perhaps be as well if first of all therefore I gave you some very brief survey of a few of the relevant activities undertaken in the Army during the war.

The most urgent need of the Army was for well-trained and efficient man and woman power. White Papers which have been published since the end of the war have now made it clear to everyone how in fact we were having to scrape the bottom of the barrel in order to try and find replacements for those who were lost to the Army in various ways. Under ideal circumstances, or in a country with less limited man power, initial selection of a much more rigid kind would clearly have been indicated. More of those who were doubtful by reason of instability or limited intelligence should have been excluded, and in that way the problems of their employment, or their inter-changeability between jobs, would have been lessened. It is, by the way, quite wrong to believe that anyone who has given evidence of any emotional difficulty in childhood or adolescence should be excluded from the Army. If the demonstration of neurotic symptoms made one unfit to be a soldier, we may almost say there would have been no Army. The real difficulty was to decide the degree and quality of pre-disposition to emotional illness which made a man unfit for Army life and work. Large numbers of men and women with long histories of minor neurotic difficulty have been able to give first rate service in the Army. Some of them have indeed been much healthier and fitter there than they ever were in civilian life.

A good many men and women, more heavily pre-disposed, broke down in the very early stages of Army training, long

before they had ever come under any fire or any of the hazards of war. Those who had never been able to adapt in civilian life, were clearly unlikely to adapt easily to the challenges presented by the Army. It is no light matter to be uprooted from your home, from your business and friends, and all your familiar grooves, and to be moved to some new place in an almost exclusively masculine environment, without privacy, and with what appears to be almost complete loss of one's carefully built-up individuality. It was not remarkable that many of these men broke down quite soon, and in fact had it been possible to have more careful and prolonged examination of their histories before they ever came in, a great number of them could have been recognised as certain misfits for Service life, and they could have been retained in their particular civilian niches, and much human dislocation avoided.

Separation from home has been by far the most potent single pre-disposing factor in psychiatric wastage in the Army, and by careful study of this phenomenon and the personality problems associated with it, we should be able to lay down some rather better standards for consideration in case of any similar emergency, and they would also be applicable whenever a shift of population or questions of the placing of certain individuals was under consideration in civilian life.

At the beginning of the war there was no selection in the Army, and almost as soon as we got psychiatrists to work (1940) it became obvious that psychological selection was one of the essentials that we must have if we were to cut down the sickness wastage, and the resultant inefficiency. From the time that the General Service scheme was established in 1942, and all entrants to the ranks were given tests of intelligence and aptitude, and interviewed by officers specially trained for the work, there was a notable improvement in the employment of men and women; square pegs, where they really needed it, were placed in square holes. Some 15 per cent. of all those passing through the General Service Selection were referred by the interviewing officers to Army Psychiatrists, either because their low intelligence presented a problem, or because there appeared to be some instability which necessitated assessment and special consideration in a decision about training for a particular arm of the Service. It is not surprising that this figure should have been so considerable. The other two Services, for some reason, had a prior choice on man-power, and the Army took what was left, so that a considerable part of the "psychopathic tenth" of the population came to the Army. By and large they did extremely well there.

Neurotic men who were in many cases able, through

Selection procedure, to be kept out of combatant service where they would have broken down, and by their general difficulty might have endangered the morale of their fellows, were utilised at the base and on the lines of communication and in units which were not primarily aggressive fighting units. The attempts at assessing what was called "combatant temperament" were undoubtedly useful. Very many of the men with a long history of neurotic difficulty who had come in before Selection started, broke down, and a great number of others of course found that they were unable to carry on in the work for which they had been trained at first. These men when admitted to military or E.M.S. hospitals could be helped up to a point, but there certainly was no time in which one could hope to achieve "cure". Consequently a scheme was devised for special posting of these men who could not honestly be returned to their old units on discharge from hospital. By an arrangement between individual hospitals and the War Office posting departments, these men were, at great pains, fitted in to specific jobs which were in line with their pre-war interests or skills, and this plan, time-absorbing as it was, paid a handsome dividend. A very high proportion of these men, who would otherwise have been lost to the Army, continued to give good effective and willing service without any further breakdown. They were not cured, but they were able to feel themselves an effective part of the Army's effort and to remain stable.

We have in civilian life perhaps been less insistent than we should upon the effort to adjust work and environment for these neurotic or unstable men and women, whom we meet so often in out-patient clinics. The Army's experience, proven by their follow-up, has shown that this is a very effective means of helping the achievement of stability. While this experiment was going on through the years at home, in the overseas theatres of active warfare, men who broke down under combatant stress were in many cases being subjected to a similar re-selection, and where it was felt that they would not be able to stand up to their original front-line work, they were fitted very satisfactorily into other roles, where again they continued to give good service and were in no way a loss to the general effectiveness of the Army.

The effects of Selection were perhaps more remarkable in the fields of Mental Deficiency. Aldous Huxley, in his fantasy "Brave New World", suggests that we should breed a special group of dullards to do the "stooge" jobs of society. The fact is, as we mostly recognise, that we already have quite enough of them, and the great problem is to see that they are not put into jobs above their ceiling, but are in fact employed where they can be useful and competent. The dull man amongst normal

men holds up training. He comprehends inadequately the regulations of an organisation like the Army and so is constantly in disciplinary difficulties. He cannot be trained at work which is beyond him. Realising his inferiority he becomes an isolate, develops anxiety, breaks down, and perhaps becomes a malingerer. Practically all the malingerers that there was in the Army, and that was not much, occurred in dullards; conscious exploitation of some minor disability provided what appeared to be the only way out of an intolerable situation. Time and effort and money were wasted on these dull men in the early days, when they found their way out round the Cape to Egypt and the Desert, and after experiences which were as trying for other people as for themselves, found themselves starting the return journey to this country within a few weeks. At various times some 70 per cent. of the occupants of our military prisons were men well below the median on the intelligence scale. The dullard misplaced is in a score of different ways a consumer of manpower and a drag upon the group.

We had not learnt at the beginning of the war that the rapid tempo and the intricacy of the armies to-day precludes the dullard from carrying on as he would have been able to do in the horse lines of the old peace-time army. We had failed to assimilate what the United States Army told us in 1918 after their Selection experiments, that their *worst soldiers* became their *best diggers*.

Eventually we were able to arrange that very large numbers of the most backward men were posted to jobs where they would be employed solely on manual labour and those who were so backward that they were really not safe to be armed went to unarmed sections of this corps. With good officers and N.C.O.s, these men were exceedingly happy and content. They were smart and reliable and they did a first class job, having at the same time less sickness and less crime than good units of the field force. These were the men who heretofore had been a social problem group in the army, as they tend to be in civilian life, and it would seem that here at any rate is one direction in which there is quite sufficient evidence to justify our doing far more than we have in the past to find the right employment and the right management for backward men and women.

Neurotic officers of whatever seniority are often more of a menace than neurotic men. The army's old saying that "there are no bad men, only bad officers", has a good deal of truth in it. Because the whole situation concerned with the selection of officers was unsatisfactory, new methods had to be devised, and the technique of the War Office Selection Boards was devised by psychiatrists and psychologists. This is no place to

give a description of the methods that were used, but for the first time a really careful survey from many angles was made of every candidate for a commission. Intelligence, character and personality were assessed with increasing certainty. Psychological testing and psychiatric interviewing found good men who would not otherwise have been accepted and prevented many, who were fundamentally incapable of giving the right kind of responsible service, from being selected for officer training.

Work based upon these experiments is being carried on in selection for the Civil Service, for the differentiation of Nazi and non-Nazi personnel in Germany, for the selection of various groups in India and elsewhere. If we can choose good officers with greater certainty, then surely good directors in industry, good schoolmasters, good doctors, can be chosen with somewhat greater success.

Selection of any kind is of course impossible unless we know for what purpose we are selecting men. Job analysis was undertaken in the Army for every one of the thousands of its tasks. This process has not as yet been carried on, save in certain small parts of civilian industry. Once such a careful study has been made, it will be a good deal more possible to make use of skilled vocational advice throughout the country, and of better schemes of advice for school leavers, and indeed for the placing of men within industry. The fact that we bother to make an accurate assessment of intelligence and aptitude has considerable bearing on the satisfactory training of men and women. The three-speed training of the below average, the average and the above average groups which was carried out throughout the Canadian Army was extremely effective. Each of the groups had their own appropriate time allotted to reach the same point in training efficiency.

Where morale is high, as we mostly realise, there will be less tendency to neurotic breakdown or to abnormal conduct. We need I think to be as fully concerned with the morale of industry and other civilian groups as we were with the study and the maintenance of morale in the army. If their morale is to be high, men must know what they are working for, and feel it worth while. They must feel competent at their job, and this they can only do if they are in approximately the correct employment and are well trained for it. They must further feel that they do belong in an integral fashion to the group, and this throws into relief the necessity for training in leadership and the understanding of human problems by all those who are in charge of others.

Partly through the study of neurotic men and women, and partly through observing groups of "normals" we have learnt

a good deal about group structure and incidentally something about group therapy. It is becoming quite obvious that we cannot have hard and fast rules for the management of human affairs. We have to study each situation carefully. In the most recent debate in the House of Commons on the coal situation, it was significant that there were no fewer than fourteen references, in five or six hours' debate, to the difficulties in the mines being a psychological problem, but no one suggested that there should be any serious and scientific study of these problems. In dealing with individuals we know that it is of little value to say "it is just nerves" or "it is just a psychological problem". We have to go further and show the nature of the trouble, and how it is to be put right. In dealing with groups or communities precisely the same procedure must be followed. We cannot prescribe a treatment without fully understanding the nature of the social sickness.

If I may draw one final lesson from our experience in the army it is this, that we must be sufficiently careful about our own morale. We must see clearly that whatever job we are doing is worth while, that we are reasonably competent in doing it, and we must so far as possible pursue the same ends as our fellows in the group. Winning the war was a serious matter. Winning the peace is far more difficult. It depends I believe upon the wisdom, balance and purpose of those of us who are here to-day whether there shall be some fresh advance towards mental Health and maturity in this country, and that is our greatest contribution to a threatened world.

DISCUSSION

Dr. G. R. Hargreaves, O.B.E. (Chief Medical Officer, Lever Bros. and Unilever Ltd.): I welcome the opportunity to open the discussion. For one reason it gives me the opportunity of mentioning what I consider was a serious omission in Dr. Rees' paper, namely, the part he played in the work of which he has spoken. Dr. Rees quoted the Army saying that there are "no bad soldiers, only bad officers." The psychiatrists in Dr. Rees' team know that they had a very good officer and that that was the main reason why the metamorphosis which he described took place. I think all those who worked with him found their point of view changing until, at the end, we viewed the problems of mental health in a light rather different from when we had first entered the Army from ordinary psychiatric clinical practice. I would summarise the changes as resulting first of all from the fact that, in contrast to their experience in civilian life, service

psychiatrists had to work as effective and responsible participants in the community in a professional role. The doctor in civil life has ordinarily a somewhat socially irresponsible role. This must needs be, since he is individually responsible to the individual patient. The psychiatrist in the Army found he had to walk the tight rope between responsibility to the individual and that to the community. It was occasionally necessary for him to make a choice and to sacrifice the one to the other. He sacrificed sometimes the communal good for the sake of the individual patient, and sometimes sacrificed the interests of the individual patient, because not to do so would have imposed great sacrifices on other members of the group.

The second change of view (and this, I think, was quite a startling fact to many psychiatrists who had previously worked mostly in the field of psychosis and neurosis) was the discovery of the literally terrific social importance of problems of mental dullness which are to be discussed in a later paper. This, I think, the service psychiatrist saw because again he had to try to be effective as a responsible participant in the community, and consequently saw people in their social roles, whereas, as a clinical psychiatrist in peace time, he had seen them only as patients. It is characteristic of the problems of dullards that their significance tends to manifest itself through social rather than medical channels and they, therefore, are far more frequently found in civil life as problems needing solution in Police Courts and schools and factories, rather than in psychiatric consulting rooms and out-patient departments.

The third lesson is that which again Dr. Rees emphasised—the fact that Mental Health work is a team job. Most of us spend our time working as individuals with individual patients, but it becomes clear that the problems of Mental Health, as they manifest themselves in the Army and every other integrated community, cannot be tackled by individuals. Gradually the individuals of the different professional groups whose work led them to the study of mental health were brought together, as Dr. Rees mentioned, to form teams constituted according to the nature of the problem to be studied. Each member of the team, whether he was a psychiatrist, a psychologist, a social worker, or a layman, was equally important, or perhaps we should say unimportant—what mattered was the effective integration of that team, and the appropriateness of its constitution for the particular mental health problems which it had to study.

It also occurs to me that it was remiss of us to wait until 1939 to make these three changes of outlook, because

this meeting celebrates the fusion, under a single title, of three organisations which made the discoveries years ago, and worked hard for many years to make their implications known. As our chairman said in his opening remarks, one of the organisations, The Central Association for Mental Welfare, took a pioneer part in making known the political and social import of the problems of mental dullness. Another organisation, the Child Guidance Council, has demonstrated the need for team work between psychiatrists, psychologists and social workers, and practised it for many years. Indeed, when we look at the constitution of the staff of an Officer Selection Board it seems remarkably like the staff of a Child Guidance unit. It has the same pattern.

The final lesson which Dr. Rees mentioned that service experience demonstrated is the terrific importance of the preventive application in psychiatry, the very lesson which the National Council for Mental Hygiene has spent its existence in teaching. Now Preventive Psychiatry, like any other branch of preventive medicine, functions not through individual practitioners, but through any coherent and integrated community. It seems to me that the Army offered particular opportunities for preventive psychiatry because the integrated community of the Army Unit was at one and the same time both the work group and the residential group. In civil life, on the other hand, the residential group as an integrated community has become completely separated from the work group, and in any case has been almost destroyed by the industrial revolution. The small town of intimately mixed social classes and occupations has gone, and now we live in concentration camps of social classes, working class housing estates, middle class suburbs, and so on. So much so, that it is now true to say for the average man the only mixed yet coherent and integrated group to which he belongs is his work group, his factory, or office, or whatever it may be. Industry offers, therefore, one of the most promising fields for the application of preventive psychiatry. But this field cannot be cultivated by any individual. It will need the same type of team work between the Industrial Medical Officer, the Psychiatrist the Industrial Psychologist, the manager, the foreman, and the Trade Union Official, that we have learnt to expect among the team of a Child Guidance Clinic. But if that team work can be developed then Industry offers great scope for the application of mental health work.

Councillor John Cormack (Edinburgh Public Health Committee): As an ex-service man I would like to make this

point: Men and women in the forces have a peculiar sense of discipline which is not apparent when they return to civilian life. Those who have them under their care in the forces can call upon them whenever they wish, but when these men and women return to civilian life, they feel a sense of freedom. The idea that they have to be at work at 9 o'clock is not regarded in the same light as being on parade at 7 a.m. While I agree with the idea of the group system, I cannot understand how this could be operated in the same way in civilian life. I hope that in the discussion we may obtain further insight into this problem.

Mrs. Vesta Gill: I have been feeling very strongly recently that people interested in Mental Health ought to do more to try and educate parents in the need of the child for winning independence. I am a member of the Nursery School Association and have had a good deal of experience in parent-teacher co-operation propaganda work, and in persuading parents to send their children to Nursery Schools. One is often aware of the terrible reluctance of the parents to give up the toddler to anybody else and the distrust with which the average parent goes about this question. Much more ought to be done in Welfare Clinics, and in talking to parents generally, to give them the idea that their job is in helping the child towards independence and making use of the educational facilities to aid them in this task. Among parents, there is not a clear picture of the education services of the country in that light.

Mrs. Jacobin: I speak for a submerged group, the housewife. It is rather a lucky chance that my speech follows that of the last speaker, who mentioned the distrust of parents in giving up their children to appropriate educational facilities. As a married woman I have had experience with young children, in addition to my professional work in Mental Health as a probation officer. I am all in favour of getting people to work as a group. The opener of the discussion said that he considers the "work group" is the only integrated social group to which a man ordinarily belongs. The housewife has no work group and has therefore no integrated group to which she belongs. I feel as a person in my family, I must be captain all the time, because nobody else will make decisions. I feel tremendously cut off from other people. The tiny problems of my home and relationships of my children to myself have become magnified. I have left home this morning a young girl just out of the W.A.A.Fs, where she said she was happy and who has come back to home with her ex-service husband and her one child, living with his mother.

She says she wishes she were back in the forces, and sometimes feels she could put her head in the gas oven. There must be thousands of people in the country who have had experience of group life and liked it, and are unable now to belong to any social integrated group: they are the parents of the children filling the clinics or courts, and who will eventually fill all sorts of social groups, good or bad.

There may be distrust in giving up our children because we are uneducated as a group. I think this perhaps affects the enormous number of unhappy homes and marriages more than anything else, and the impossibility of young children and mothers getting into any integrated social group. I hope that this organisation, while thinking of the more scientific side of its work, will not forget that people are coming out of homes where they are cut off from integrated social life.

Miss Vanda Steadman (Coventry): Dr. Rees raised a point as to a gap and I felt I would like to express my views as to what that gap is. It is the lack of the complete home. Over a great many years I have tackled a number of jobs: in the Labour Exchange, in Industry, in Local Government, Day Nurseries, dealing with the war-time evacuation of mothers and children, and also all the various domestic problems that have arisen. I now find I have come back to the problem of the young girl with her illegitimate baby, wanting occupation, wanting means of sustenance, wanting comfort, and all the way through, in every stage, I find the need of the home life.

The last speaker referred to the need for societies and for companionship. In London I only had the experience of mothers coming to the clinics, who wanted companionship. There they found it. In the provinces I find on every hand that there is an Association to meet the needs of every mother who wants one, but very often these mothers are more keen on going to meetings and associations than in taking the joy they should in their homes and children. I feel that it is an important matter for us to consider. The home is the basis for everything. When I worked many years ago in the Labour Exchange, I was struck by the people applying for work and getting the dole over a long period—those who were unemployable and had to be regimented into some order if they were to be of any use to themselves or to the community. Had they had a proper home in the first place, they would never have got into that state, and I feel that much of our work now should be concentrated on looking after those people who are unemployable and have not a home. First a home and then the application of Dr. Rees' principles.

Dr. A. M. Wyllie (Physician Superintendent, Royal Mental Hospital, Aberdeen): During the war I had the privilege of being Second-in-Command of a Military Hospital for Officers suffering from psychotic and psycho-neurotic breakdown, and am now Superintendent of a Mental Hospital in Scotland. I am impressed by the difference in the mode of admission between the Army patient and the civilian patient.

In the former case, admission is simplicity itself, in the latter, the admission is complicated by a variety of legal forms. The Scottish Lunacy Laws are at present under revision and I hope the opportunity will be taken to make it easy for the general practitioner to get his patients into hospital at an early stage in their illness. I think that simplification of the laws should be the keynote of the revision.

Dr. F. J. S. Esher (Medical Officer, Mental Welfare Service, Sheffield): Since my return from the forces, I have been going through the cases of a large number of defectives notified to the Sheffield Local Authority for care and supervision. In considering these, it is clear that those coming from sound families are on the whole well employed, well-behaved, well balanced and happy, and quite a number are married satisfactorily. It is this sound family background which makes for the formation of a sound personality. Low intelligence is a lesser handicap as many occupations require very little intelligence. Poor personality, however, will ruin the lives of even the intelligent.

I would like to say something with regard to the marriage of defectives. This is a controversial subject. Most people think in terms of sterilising them, but I do not think this is necessary. Institutional care is obvious for difficult cases, but sound management in their homes will often turn unsatisfactory defectives into social and useful persons. In Sheffield I have seen a large number of defectives leading perfectly satisfactory lives. I have no figures to offer you, but my estimate would be that something like 80 per cent. of all the cases notified for statutory supervision are behaving adequately in that area. Many of our defective girls have married reliable normal men and manage to keep good and respectable homes, cook good meals and keep the house clean, and are quite a credit to the city in which they live. I consider that sound advice to these people, especially when newly wed, which is one of the things we are doing, is of immense value.

Dr. J. R. Rees in replying to the various questions pointed out that the best kind of discussion would be between in-

dividuals after they had left the Conference. The relationship between Vocational Guidance Centres and the Employment Exchanges might be very much on the same lines as that in the Army between the technical workers (psychiatrists and psychologists) and the combatant officers who were employed in Selection work. He stressed the fact that no one wanted to carry over Army discipline into civilian life, but that in any case morale was very much more important than discipline. The latter tended to follow the former. On many of the other problems, such as those raised by housewives, there was clearly need for research and experiment with local groups and communities.

The Chairman: It seems to me that the second subject on our agenda is the perfect corollary of the first. It deals with the employment of the mentally and emotionally handicapped, and I have much pleasure in calling upon Dr. Main to speak.

The Employment of the Mentally and Emotionally Handicapped

T. F. Main, M.D., D.P.M.

(Medical Director, The Cassel Hospital)

The employment of the worker of poor intelligence is not a vastly different problem from that of the employment of the worker with an emotional disturbance or indeed of any worker. All workers become unhappy and inefficient if they are placed in unsuitable settings, but potentialities differ widely, and the two groups with which we are concerned need some understanding of their special tendencies in various settings before we can usefully advise or help them.

Low intelligence is not of itself the only problem of the mentally handicapped; it leads to failure, perplexity, loneliness and fear in the face of a competitive, industrial world, and these resultants sometimes create greater difficulties in employment than the defect itself. The reasons for these added difficulties are not far to seek.

It is not easy for a handicapped child to accept the fact that to others it seems stupid, nor to survive the disapproval and reprimand and mockery it may get at school and elsewhere without deep mental wounds. If the defects of behaviour are great enough it will get the advantages of special schools, perhaps special industrial training, and a chance of adult life in a community where it can successfully compete with others with

similar handicaps under special conditions. If, however, the handicap is not great enough to qualify the child for these sheltered conditions, life remains a vast, puzzling, and often uncomfortable affair. At schoolwork, in games, in social acceptance, in the approval of adults, in achievement and fulfilment of childish ambitions, it has to face constant, unending failure, no matter how hard it may try. After leaving school it is unlikely to fare better, and, as illustration, here is an employment history taken in 1941 of a backward man of 24:—

Paper boy, 3 months; errand boy, 4 months; unemployed, 4 months; grocer's bicycle delivery, 2 months; unemployed, 6 months; tea boy in foundry, 2 weeks; office boy, 3 days; unemployed 6 weeks; errand boy, 8 months; unemployed, 3 months; Wall's Ice Cream, 4 months (in the summer); paper boy, 3 months; lavatory man, 8 weeks; unemployed, 1 year; lorry driver's mate, 6 months; unemployed, 1 year; builder's labourer, 4 months; newspapers, 3 months; hawker's driver, 1 month; unemployed 18 months.

Life on the bread line is unsettling in itself, but for many people of modest intelligence poverty is only one feature in a life history of chronic shame, of discouraging failure at school and work, of social contumely and domestic indignity. The world appears to many of them to be complex, bewildering, hurtful, difficult and sometimes hostile, and life something to retire from and avoid. Reading and writing is difficult for them, leading to failure to follow the news or to understand new legislation and this in turn makes for social disorientation and confusion and insecurity. The forming of human relations on equal terms is also difficult for the mentally handicapped. It is not easy for them to feel at ease with strangers of higher intelligence or greater social dignity or financial stability. This complicates their other difficulties of social expansion, and often they tend to cling to their own poor kind with whom they feel at ease, and to marry someone who can share or understand their attitudes, some one who will not, as others might, criticise them, censure them, blame them for failures or stupidities or become impatient of their views or intellectual span. Many have found thus a pattern of life which suits them, or at least avoids major hurts for them. Humbly and timidly they may share their puzzled insecurity and poverty with a wife or husband of no great intelligence, holding simple blind alley jobs and spending their money without planning or foresight, enjoying limited social contacts and avoiding the larger social situations in which they are at a disadvantage; even if enjoying stable employment few, by their very nature, are able to cope well with their economic affairs on the commonly small wages that simple jobs produce.

Many have wives who can manage no better than they, and yet family expenses may be considerable. An intelligent person would find it difficult to handle similar responsibilities on comparable wages, and these people need not less but more money than the intelligent if they are to afford minimal civilised standards of housing, clothing and feeding. The liability to lose one job after another is a further fact of life that could not easily be faced by a person of higher intelligence. The mentally handicapped need indeed not only security of employment but knowledge of that fact to an extent at least as great as any building operative to-day.

These two things, good wages and secure employment, are not, however, enough. There can be no industrial settlement unless there is also social and domestic settlement. Their difficulties in feeling at one with the communities in which they are set, and their social disorientation, mean that they need counselling service to which they can turn for advice and explanation on such matters as housing, rents, clothing, food, maternity services, education, health, that they may understand and use fully the social institutions which surround them and learn of new statutes and the industrial opportunities which may affect them. Indeed, the employment of the mentally disabled is but a part of the larger problem of their fuller integration with society. Without such integration they are liable to be timid, shy, fearful, unhappy or inefficient, often ailing with minor complaints, despairing, sullen, unco-operative, delinquent, or criminal. It must be pointed out that in every hundred people there are ten who belong to the submerged tenth and of these many are unable to manage their lives without some advice, help or planning (if this word is not too unpopular) from the other ninety. As things are, freedom in a competitive labour market is apt to mean all too often, for all too many of them, slavery to uncertainty and worry. Yet their potential in happy citizenship and in their work is considerable.

We know of course how to handle the situation when the handicap is a severe one. Colony life or the new opportunities arising under the Disabled Persons (Employment) Act of 1944 are two means of dealing with it. The commoner and socially more important task of aiding the efficiency of those with distinct but less obvious handicaps needs additional consideration, for although the Disabled Persons Register can be opened to them, they must first be identified, and this of itself is not easy. They are not proud of their limited capacities and their past failures in the employment market, and they try in shame to hide their inferiority. They do not walk into out-patient departments complaining of limited capacities. A life-time's experience of occasions of ridicule, condemnation for stupidity, and of being

despised for their insignificance, has often given them a small expertness at concealing their handicaps. An odd man at a fair booth may become an "assistant entertainments caterer", and "household salvage merchant" has dignified at interview a man who picked rubbish heaps for scraps. Nor is any trust to be placed in any man's professed capacity to diagnose intellectual handicap at an ordinary interview. One of the commonest fallacies held to-day by otherwise quite sensible men is that they know how to read character and sum up a person, and the more tenaciously it is held, the more it should be suspect. Certainly, no man likes to think he is easily fooled, but objective criteria are essential if this problem is to be put on a rational basis.

The proof of difficulty at work will be in the past record. Any worker who, over a period, consistently shows slowness in learning or difficulty in holding jobs or in settling into jobs, even if the overt reason for the unsettlement is ill-health, should be offered free expert medical assessment and advice. Full physical and psychiatric examination should be given so that a total prognosis in terms of industrial potential might be arrived at. Such a service would be useful for others than the mentally and emotionally handicapped, and should include them. It is certain that the existing channels for referring a man for psychiatric assessment from the Ministry of Labour are blocked or narrowed by lack of knowledge and prejudice and the fear of stigmatising the mentally handicapped. This latter fear could be avoided, however, if the opportunities for full assessment were opened to other classes of workers in difficulties, and many a man suffering, for example, from poor vision, would be helped better by advice which recognised also his intellectual capacities than by that which regarded only his visual handicap.

Again, there are those who feel that dull men would be unhappy if the fact of their low intelligence was discussed as a problem to be dealt with, and that the men and women involved would acquire a sense of inferiority. But the majority of these men and women already have a sense of inferiority and are well aware of their own inability to grasp knowledge as easily as other people. They hide their defects and their problems, not so much to avoid their discussion and solution, as to avoid the contumely which hard experience has taught them to expect when they reveal themselves. They are considerably relieved, however, when they find some one who can recognise their handicap and discuss it as a practical problem, without patronage or intolerance. It is rare for them to find that they are understood, and where such understanding is coupled with advice and practical measures to find them suitable work, they are grateful for discussion and glad that their problem is recognised. If the

present chronic flirtation of the Ministry of Labour and the psychiatric services were to ripen into an organised engagement and a solid marriage, these people, inescapably their children, would enjoy being legitimised.

Their industrial potential, given stable domestic and social integration, is of course considerable, and even where their work needs to be subsidised—as it can and will be in the British Factories—it has a peculiar value for any community. This is because it can concern many of the tasks which would bore more intelligent men to the point of dissatisfaction. Manual work of a simple repetitive kind in a stable, industrial background is the kingdom of the dullard.

The jobs themselves are easy enough to nominate, but the industrial background is as important. Machine minding, for example, may be simple enough to suit a mentally handicapped worker, but the machine itself, the noise it makes, the complexity of the machine and of the product, the predictability of events in the vicinity of the machine, the degree of simplicity of the factory's hours, routine, rules and management, may be the factors which decide whether or not the simple job is suitable after all. Much depends on how far the worker can identify himself with his machine and environment, both of which must be simple enough for him. A simple job on a complex machine may be less welcome than a fairly complex job on a machine whose working is simple enough to be understood. An elementary job which takes a worker to a different place every week may be less welcome than a fairly difficult job in a stable, familiar setting. The settling into the job, the acquiring of a sense of "belonging" to the job and the work-fellows, and the "wait" to receive the satisfaction that comes from being a familiar accepted member of a work team are initial emotional tasks that loom large amongst the difficulties which confront any man approaching a new job, and in selecting a job for the dull worker, the degree and quality of his social estrangement or uneasiness should be considered. The settling-in period needs recognition as a time of intense adjustment to a new total setting rather than to a mere job, a time for socialising the individual and promoting emotional integration with, as well as intellectual orientation to, the new rôle.

It is already plain that the problems of employment of the mentally handicapped are not only those of limited intelligence but of the whole individual and his whole social setting and that in many respects the emotional problems involved are similar to those faced by the emotionally handicapped. The medical diagnosis, fascinating though it may be, is, in fact, often less important industrially than the social diagnosis of these men and women, and there is much to be said in this context for assessing

the emotionally disturbed also not in the medical terms which imply suitability for certain medical treatments, but in the terms similar to those that have been used for the mentally handicapped and which refer to their industrial and social needs—degree of industrial discouragement and aspiration, degree and quality of difficulties about social orientation and community integration, security needs in job and in wages, need for subsidised wages, need for counselling service in social and domestic affairs, capacity for identification with a job, special domestic, social and industrial sources of anxiety, settlement difficulties of the transitional period.

The epileptic, the schizoid, the obsessional, the depressed, the hysteric, indeed all those who are emotionally handicapped, have difficulties in their working relationships which need further study and understanding. It is not sufficient to give medical treatment and then expect them to settle into a working community carrying burdens of invalidism, shame, social isolation and insecurity as best they may. After medical treatment and often during it, many need the shelter of a transitional society in which their difficulties may be formulated and examined in relation to a working environment and in which they may receive help to re-establish their damaged or tenuous social attitudes before passing on to independent effort. Linked with this transitional society in which full medical and psycho-social diagnosis can be linked with industrial training and resocialisation, there should be opportunities for sorting out and settling domestic problems, for acquiring a working familiarity with social institutions, and for trying their hands at the kinds of jobs to which they will eventually go. This is no new technique—it was used in the resettlement of returned prisoners of war with damaged attitudes—and has applications to other than mental and emotional handicaps. The word “rehabilitation” could be applied to such treatment and training centres, and if these allowed recognition of the fact that man is a social animal with immense capacities for growth and repair as well as a mechanical source of industrial energy, the word would be appropriate.

Last week in an Employment Exchange I discussed with an energetic and sympathetic Ministry of Labour Official the problem of a man on the Disablement Register. His difficulties had been slowly recognised over a period of 4½ years during which the indefatigable efforts of the Ministry had managed to get him 46 different jobs. He had consumed an enormous amount of time from the Ministry, from the local workers of this Council, from the Disablement Rehabilitation Officer and from doctors, but no conference of experts in treatment and rehabilitation and employment and counselling had ever met *together* on

his case. His social background and medical condition and employment had all been considered, but as separate, related problems rather than as various aspects of the same problem.

Industrial case conferences are needed if psychiatric illness—so costly to the nation—is to receive the attention it is due. It should be possible for the Ministry of Labour to offer from its own resources full medical (including psychological) examination and diagnosis and to get a recommendation for action from a team on which might sit in conference a Disablement Rehabilitation Officer, a social worker, a general practitioner and any medical specialist such as a psychiatrist relevant to the case. Similar teams would be needed in rehabilitation centres for those who elected to go for treatment and training, to assist in the final job recommendation and selection. The job recommendation need no longer then be made by a medical man in isolation from the facts of the employment market but could be matched to the vacancies and opportunities known to exist at that moment, and thus be practicable. The Disablement Rehabilitation Officer in turn could arrive at his own decisions not from a form, but after full discussion of all relevant facts. The workers' own feelings and preferences would be fully known and any needs for treatment, rehabilitation, domestic counselling, after-care and problems of settlement into the chosen job could be faced then.

It would be a matter for such a service, after total diagnosis, to arrange the necessary treatment and job selection and to make recommendations on settlement techniques. These resettlement techniques need not be confined to Rehabilitation Centres but should operate in every work place possible. Transition to some jobs may always be difficult to manage, but entry into a British Factory should be such as would permit the worker to spend an initial period in general orientation, to let him or her get the feel of the work place and the workmates, the foremen and shop stewards, to learn at a pace within his or her capabilities of the rules and social structure of the factory. During this time the worker would be given a chance to acquire a feeling of familiarity and of "belonging" to the firm, to try out his hand tentatively at the jobs open to him and to identify himself with them and the machinery involved before settling down to routine work. During this settlement period and after, there should be full opportunity for the worker to attend social occasions, ask frank questions and to get information from a counsellor—perhaps trained by this Association—who knows not only how to teach the worker his job but who understands his special and general needs as a human being.

The needs of the mentally and emotionally handicapped are then greater than "a simple, quiet job," and the methods

here suggested to help the total settlement of the socially handicapped are merely examples of what might be done. There may be methods of tackling their problems other than these suggested. But to identify them in detail, to give treatment and training for the complex problems of living and working handicapped as they are, to provide a method of job selection and a technique of industrial settlement, and to create a consulting and after-care service to help with domestic and social needs, appear to be basic desiderata. At present most Disablement Rehabilitation Officers regard psychiatric cases with much misgiving, for they know that interest and unlimited goodwill within the present arrangement do not and cannot settle in a satisfactory manner the problem of their employment.

DISCUSSION

Mr. R. E. Gomme, O.B.E. (Assistant Secretary, Juveniles and Disabled Persons Dept., Ministry of Labour and National Service): May I first of all express on behalf of my Minister our appreciation of the initiative of the National Association for Mental Health in summoning this Conference and giving us the opportunity of being present and listening to this discussion. Dr. Main in his paper has put forward a number of ideas and suggestions that demand most careful consideration by all concerned in this problem, and especially by those who have direct responsibility. My own department has a direct responsibility because of its work under the Disabled Persons (Employment) Act, and we shall certainly consider the points he has made. The field he has covered is somewhat wider than that of the Act, but the lessons that we are learning and the developments that we are trying to bring about in our administration of that Act, will have, I hope, results over the rather wider field to which he has referred.

From our general experience in the Ministry (we started our scheme before the Act came into force) of dealing with the emotionally and mentally handicapped, we found that the group as a whole was unquestionably difficult and, in proportion to the total, rather alarming in those early days. It was then round about 20 per cent. of the whole field of the different types of disablement, surgical and medical and others. Under the Act, since registration was started, that proportion has not been maintained. Registration is now in the neighbourhood of 700,000, but the proportion of those in the group of psychiatric disorders is round about 5 to 6 per cent. I should imagine that that does not give a correct picture—due to the reluctance of people in this group to

come forward for registration. That is a difficulty which can only be overcome through a far closer link between the Employment Exchange service and the medical services and the psychiatric and social workers. We are trying to develop on those lines, as I will indicate in a moment, but whatever the exact proportion may be, the problem itself and the number are serious. I may perhaps indicate too, that we are trying to deal with it through the system of industrial rehabilitation centres, as the Act calls them. We started one centre some time ago in Egham where we were advised not to take cases of psychiatric disorders other than of a very minor character. We are contemplating in the near future a considerable development by taking over a number of civil resettlement units from the Army and, I hope, learning from them—taking over some of the staff and the very valuable experience that they gained during the war. The general scope of these Centres will be very much wider than at present. There will be a certain amount of psychological reconditioning. I hesitate to use technical terms in the presence of so many experts, but I think that is right—psychological as well as physical reconditioning, together of course with the development of vocational training. At present our energies must necessarily be directed to the problem of training to meet the urgent needs of industry at the present time, but as that problem diminishes we shall be able to concentrate more on the vocational training of the disabled, including those with psychiatric disorders.

Another measure which we are developing is the provision of special factories where severely disabled people can work under sheltered conditions. It is our hope that, after a period of employment in those sheltered conditions, a very considerable proportion of the people will be sufficiently recovered to be able to take their place again in ordinary competitive industry. Our object throughout is to achieve satisfactory resettlement. Our greatest difficulty—a difficulty to which Dr. Main has referred—is to get an assessment of the disablement and of its effect upon employment and employment capacity. We have had the assistance, for the Ex-Service Group, of the psychiatric social workers under the arrangement which we have with the National Association for Mental Health, and I should like to take this opportunity of paying a tribute to those workers for their help. So valuable has their help been that we are now considering, with the Ministry of Health and the Board of Control, whether it could not be extended to the whole field.

There are two other developments which, I think, meet some of the points that Dr. Main made. A difficulty that

we, as a lay service, have in dealing with any form of disablement, but especially in the psychiatric group, is that up to now we have been proceeding on the basis of written medical reports. That has obvious disadvantages, principally because it leaves the interpretation to laymen. We are now proposing to set up something in the way of a medical interviewing service, where we shall have interviewing boards or committees consisting of medical men who will not merely interview and examine the patient but will be available for direct consultation by our own Disablement Resettlement Officers. There will be discussion and consultation in each case on the meaning of the disability in terms of capacity, and therefore on the kind of employment likely to be suitable. That direct contact should, I think, prove of immense advantage both to ourselves and, we hope, to the medical members of those committees, and we have not forgotten in the proposals we have for those committees the need for special action with regard to the psychiatric group. Dr. Main referred to the present relationship between the Ministry of Labour and the Psychiatric Services as a chronic flirtation. I do not know if the proposals we have in mind will produce a formal engagement, but may I say we do propose at any rate to walk out together.

The other development we have in mind belongs rather to the Health Services than to my own Ministry, and that is the setting up of an assessment or diagnostic centre, where cases of emotional and psychiatric disablement will be under medical care and supervision, so as to permit a more accurate diagnosis in terms of employment capacity. We are following there the very successful experiments that were carried out at Dartford for returned prisoners of war. There again there will be a very close association, more than a flirtation, between our own services and the medical services at the centres. This will be an experiment but we have hopes—and I think our medical advisers also have hopes—that it will develop into a really useful and productive unit. I think it may be said that those developments in those broad outlines are substantially in accord with the views that Dr. Main put forward in his paper. I wish very much that I could say that those developments are coming into force, or indeed that they are in force. Unfortunately this is not so. All these developments involve sites, or buildings, staff and organisation, which are beyond our capacity at the present time for reasons entirely outside our control. We have many other tasks in hand, but I think I can say that at any rate in the course of next year there will be very substantial developments along the lines I have given. Dr. Main has stressed the value of

team work and I can assure him and you that that is entirely in accord with our views at the Ministry of Labour. We are profoundly conscious that in the period between the two wars the Employment Services were working somewhat on mass lines. Unemployment reached a very high figure and we were compelled in our Employment Exchanges throughout the country to deal with numbers in an atmosphere that prevented any kind of satisfactory individual selection and attention. With the declared policy of the Government on full employment, we may hope that those conditions will not return and we are preparing now, through the training of our officers and in other ways, for a far more individualised service of vocational advice and guidance. In that way we shall certainly need the advice and the co-operation not merely of the medical services, but of the various social services who are already in this field. Among the more important of these will be the psychiatric social workers provided by this Association.

Councillor John Cormack (Edinburgh Public Health Committee): Dr. Main mentioned the words "special school" or "sheltered care". I maintain that the young man and woman emotionally handicapped is more than ever handicapped by having been sent to what is termed a "special school." A child who is sent to a "special school" is stigmatised. Children know immediately that there is something wrong and the term antagonises parents who otherwise would be glad if their children could obtain special care. I suggest that this great organisation should send a resolution, or suggestion, to Education Committees all over the country, urging them to try to get rid of this term "special school".

Miss S. A. Abley (Regional Representative, Region 7, National Association for Mental Health): I am sure all of us here who are social workers are gratified to note the emphasis that has been laid this morning on our part in rehabilitation and our part in treatment—using the latter word in its widest sense. I have had some experience for over seven years in the community care of the mentally sub-normal and I am glad to say that where your ascertainment is early, where you have Special Schools established and they are accepted in the community, where an After Care Scheme and social workers are available, you can expect to get, and do get, satisfactory employment results. The Birmingham Education Committee, where I was a Special Schools After Care Officer, has a unique scheme for after care. It covers about 4,000 cases and the percentage of those in employment is well over 60 per cent. This includes all the low grades living at home. We were not only dealing

with juveniles and adults considered to be employable, but out of the total number there was always more than 60 per cent. at work. One of the important factors for success is the availability of records. Where medical, psychological, school and social records are accessible to the people making decisions, you can get good results from the work put in. Of course one still has to work hard and no grievance is too slight to be investigated, particularly at the beginning of the employment career. It is an asset to have local firms catering for those able to do work of a routine nature, and where your after care scheme is long established it is a comparatively easy matter to have close and fruitful co-operation with employers.

Dr. T. F. Main (Medical Director, The Cassel Hospital): It is with great pleasure that I have heard of the Ministry of Labour's intention to go "steady" with the psychiatric and psychological services, but we must not rest content merely because the Ministry of Labour joins in. It can only settle a part of this problem; employment is merely one aspect of the larger problem, the *total* resettlement of the mentally and emotionally handicapped. It seems to me, that to solve only the industrial problems of employment of these people is to pay lip service to what they need, which is settlement into society and into community with total domestic and social settlement *as well as* industrial. Domestic affairs and the social affairs may cause industrial unsettlement, no matter how well placed in industry they may be.

The Ministry of Labour in consulting with doctors is not doing very much more than it has done in the past. Any consultant body of doctors and Ministry of Labour officials needs to include representatives from the societies which have in the past looked into the social affairs of these people. Local authorities, too, will have to play their part in order that full knowledge is made available concerning the use of the social institutions of the area. The Ministry of Labour has plans that are an enormous advance on those of the past, and I am sure that the Ministry is doing all it can to settle the problem of employment under issue. However, it remains also a matter for Social Services and Municipal organisation.

The Chairman: I think you will agree that there remains little more to be said by me as Chairman. Two things stand out in my mind: The first is that when consideration is given to a problem of this kind, the great need of to-day is to look at things positively, to look on the question of abilities, how these persons can fit, rather than worry about the defects. I like the distinction Dr. Hargreaves made between the first complex and

the other. I should commend particularly Beatrice Webb, because she, above all people, set a target of preventing or getting in front of disability and its consequences. Someone mentioned to-day—this is my second point—the now unpopular word “planning”. Planning is another of these words like lunacy that has taken on a rather bad meaning in the course of time, but, when you come to this, whether it be special school or any other thing, I am sure that the right way is to make your plan so good that it is universally valued. If planning is well and wisely and conscientiously done, then we are going to prosper. Julian Huxley, in a recent book, had a good word for that. I will quote it to you in conclusion:—

“We are living in a revolution. To live in a revolution is a doubtful privilege and this particular one particularly unpleasant. But to be in it and refuse to recognise it is the height of folly. But there is one compensation. This revolution is the first in which scientific knowledge and conscious planning are able to play a part. History is being made at a greater speed than ever before and, if we are willing to make the effort, we who live in this revolution have the privilege of helping history.”

END OF MORNING SESSION

THURSDAY, NOVEMBER 14th

AFTERNOON SESSION

Chairman:

P. Barter, Esq.

(Chairman, Board of Control)

The Chairman: The subject for discussion this afternoon is “Community care in relation to the extended powers of Health Authorities under the new National Health Service Act.” We are fortunate in having Professor Aubrey Lewis as the first speaker. The discussion will be opened by Dr. Maclay, and later in the afternoon the Minister will address the Conference. With such a galaxy of talent before you, I feel sure that in opening the proceedings it is only necessary for the Chairman to detain you for a few minutes with one or two general observations.

The purpose of the National Health Service Act, as stated in the first section, is to promote the establishment “of a comprehensive Health Service designed to secure improvement in the physical and mental health of the people.” Accordingly the Act

provides for the integration of the Mental Health Service with the National Health Service centrally and locally.

Locally the Service will be administered through two agencies. The Hospital and Clinic services are parts of the services provided by the Minister of Health, and will be administered through the Regional Boards and Committees of Management. Community Care services will be primarily the responsibility of Local Health Authorities.

The administrative problem here is obviously going to be the imperative need of securing a proper link-up between the hospital authorities and local authorities. No doubt we shall hear much about it this afternoon. Another problem stands out quite clearly: that is the need for training and recruiting more staff for the Community Care Service. Not only are these insufficient now, but clearly they will be insufficient to face the increased demands that may be made on Mental Health Service. The National Health Service results automatically in providing a wider scope for the Mental Health Service. It will no longer be limited to cases falling within the definitions of the Lunacy and Mental Treatment Acts and Mental Deficiency Acts, but will naturally be extended to cover the milder forms of mental and nervous disability and mal-adjustment. The need for this has of course been emphasised by our war time experience. The After-Care Scheme for Service Men and Women, in which the Provisional National Council and their regional After-Care officers and social case workers have done such splendid work, has shown how much there is to be done in treating and rehabilitating persons who have difficulty in adjusting themselves to normal employment and occupations. May I give you just two or three significant figures? During the last twelve months for which figures are available, 3,457 new cases have been referred to the Provisional National Council under the After-Care Scheme. In the first six months, out of 1,794 cases 1,153 came direct from Service hospitals and 641 from civilian sources. In the last six months, however, out of 1,663 cases 871 came from hospitals and 792 from civilian sources.

In the extended sphere of Community Care there will clearly be an important field for the work of voluntary associations represented by the National Association for Mental Health. I am not unnaturally inclined to take a favourable view of the official machine; but I recognise that many persons though they shrink from contact with this machine, can be steered to the facilities for treatment by the intervention of some voluntary agency. That is going to be very important in connection with one of the primary duties that will devolve on Local Authorities under the new system. I refer to the initial picking up of persons who need care and treatment. If that work is not well done,

the development of the hospital and clinic services will be largely in vain. It will not, however, be enough for us to have an adequate supply of trained and social workers. There is a great need for the creation of a better-informed public opinion. Here the propagandist work of voluntary bodies can be of the greatest value. The purpose is well served by conferences such as have been arranged by the Provisional National Council and, in particular, in discussions such as we are going to have to-day on Community Care.

ADDRESS by
The Rt. Hon. Aneurin Bevan, M.P.
(Minister of Health)

I was delighted, when I was asked to come along this afternoon, to accept in order that I might have the opportunity of speaking to so important a body of informed people on which is one of the most important aspects of public health—a body of opinion very much more informed than I am myself, and you will therefore, I hope, forgive me if what I have to say relates much more to the administrative side of the problem than to any attempt at a clinical approach. That I must leave to the experts. I am concerned, as Minister of Health, to put at your disposal—to put at the disposal of the professional workers and all the voluntary workers—the best possible kind of administrative apparatus, and then to leave you to use it to the best of your discretion.

There has been some apprehension expressed in certain quarters, now that the Health Act has been passed, that the Minister would impose his almost unlimited ignorance upon the general body of professional conduct. Those who feared that do not properly understand the relationship between the Ministry of Health on one side and the technical help of the special workers on the other. It is not my business, nor that of any other Minister of the Crown, to dictate to people how they should use their specialised knowledge. It is, however, the business of the Minister to put the best kind of facilities at the disposal of the experts.

I want, in the first place, to congratulate you upon having incorporated into one organisation the three voluntary organisations. It will have the beneficial effect of enabling you to co-ordinate your activities more efficiently, and have the corresponding advantage of enabling us to meet one authorised body of opinion instead of three. In the life of a busy Minister that is a consideration not to be despised.

I want also to take this opportunity of expressing to you, on my own behalf and on behalf of my predecessors, our very grate-

ful thanks and appreciation for the excellent work you have done. The Ministry of Health has, I think, got a very good reputation in its relationships with health workers generally. I know, however, that there is some apprehension concerning the relationship of voluntary workers to general health activities and in particular in the Mental Health field. I would like to take advantage of this opportunity to make one thing very clear. The new scheme does not mean any diminution in the field of voluntary activities. On the contrary, it will extend it. We have accepted, and the State has accepted, the obligation of removing financial anxiety from doctors. It will be, I think, when the Health Scheme is in full operation in 1948, one of the most lasting recommendations of our own system—we shall be the first nation in the world to remove financial anxiety from the doctor and his patient. That is good, because—using technical language with which I am not too familiar—financial anxiety neurosis is almost as bad as any other. I hope my friends in the medical profession will agree with me, that this is only the beginning of good health; a patient should be able to seek the services of a doctor without any financial inhibitions, but a doctor himself will be able to treat his patient rather better if he himself no longer has a sense of private adventure in the field.

Therefore, we are about to embark on a National Health Service, which I hope will start under the most happy auspices in removing from the field of health this financial consideration which in the past has often deterred people from seeking assistance.

I know it is present in the minds of many of you that the assistance that voluntary organisations can render in the field of Mental Health, may to some extent be modified, if not injured, by the fact that community care will be under the Public Health authorities, while the provision of a clinical assistance will be under the Regional Boards. Many people are apt to feel that this is a defect in the service, that it would be very much better administratively if all these functions were administered by either the one or the other. I appreciate this anxiety. It has been expressed in a number of quarters about other aspects of the Health Scheme; but I believe it shows a fundamental misunderstanding of the nature of the scheme itself. It must be remembered that these different associations under the Health Scheme will be co-ordinated by the fact that all the Health Authority medical officers, the general practitioners, the specialists, the consultant, the surgeon, the gynaecologist, the psychiatrist, will be consumers of the same facilities; that is to say, our Public Health Authorities will not be providing facilities merely for people having claims upon them, but will be providing instruments, institutions and facilities, that are available as a

part of the National Health Service as such, and therefore will be unable to deny access to those facilities to any citizen in the land, because one of the features of the Health Scheme for which we have now secured Parliamentary approval, is that it is a universal scheme freely accessible to every citizen in the country.

This conception of a common user must really be got right into our minds. The hospital will not be able to deny itself to anyone who needs it, nor will the Public Health Authorities be able to confine their services to persons living within any circumscribed area. In other words, what we are doing is creating a universal health apparatus and giving its administrative responsibility to a variety of different agencies. But the fact that you have got in the Health Service itself a variety of administrative agencies does not destroy the essential integration of the Health Service as a whole. It will not be necessary for anybody to produce a contribution card; all it will be necessary for him to do is to prove to the person able to judge that he is in need of some assistance of one kind or another. When he needs that assistance it must be our privilege to give it to him.

Just one word, therefore, about organisation. We are very unusual people in one respect. We have always revealed a happy genius for being able to weld the individual enthusiasm of voluntary workers with Municipal and State organisations. I know that sometimes this marriage is accompanied by a few quarrels, but then such are the vagaries of nature and connubial felicity. We must not allow ourselves to be depressed because here and there one or two difficulties arise, but it will be part of my job as Minister of Health to encourage Public Health Authorities to make more use of voluntary organisations and the experience and knowledge they have gained—in the first place, because very often the voluntary workers are able to approach the individual who is suffering from mental stress, in a way which any official finds it difficult to do. The relationship between the two can be very much more informal and more extempore. The official is apt to want to classify the case rather too much and to fit it into its proper category, whereas the individual, especially in the field of Mental Health, is a separate case to himself and, while classifications are necessary for scientific treatment, individual therapy is necessary for sympathetic treatment. There is that old folk song which says, "One is one and all alone and ever more will be so." It is absolutely essential, in the field of Mental Health especially, that the individual should feel he has available to him a sympathetic organisation without any abstract or objective dispassionate outlook. Therefore I hope the Public Health Authority will make use of voluntary organisation to the utmost extent.

There is another field now open to us. It seems to me of the utmost importance that people who feel the oncoming of mental stress should be able to receive advice and assistance as early as possible, and that they should be able to receive it, not in any isolated or special sense; that our hospitals must be fitted up with a psychiatric centre, so that the person who wants assistance or advice on mental health will go to the general hospital and consult in the same way as other people with other forms of disability.

The separation of the individual who wants assistance for mental stress from the rest of people requiring help is a bad one. It helps to establish a psychosis in the very beginning. Everybody here knows very well that all of us suffer from mental stress at some time or another and many of us develop all kinds of psychoses we would not be prepared to admit; but the borderline between mental health and mental ill-health is so blurred, there are so many nuances and half-tints and semi-tones between a person in good mental health and one who is not, that it is an outrage that any artificial isolation should take place between them at an early stage. Therefore, it will be part of our duty when we come to organise the hospital system properly and in full operation, to secure that there shall be facilities available at the hospitals for consultation with those persons who want assistance and advice on the mental health side. Furthermore, it is essential that, when there has been consultation, if any follow-up care is required there should be people ready to do it, and that there should be continual contact between the patient and those able to give him assistance. There are large numbers of men and women demobilised from the Services with neurasthenia or some form of mental distress. They require assistance, and help and advice to enable them to obtain suitable employment, because one of the most effective ways of seeking to restore people to normal relationships with their fellows is occupational therapy. You know better than I, that many people who thought they were going rather odd, have been restored to channels of mental health by being put into the right jobs, being given the right thing to do, and the right sort of companionship. Therefore, in addition to early diagnosis, the fitting of people into the right places, the right kind of industry, is a very important part of mental health.

I would like to say one word more. I am beginning to tread on extremely dangerous ground, but, speaking purely as an amateur, I do think we want to guard ourselves against the assumption that the discovery of new words is at the same time the discovery of new ideas. I have very many friends who are psychiatrists, but I sometimes wonder whether some of them have not discovered a new terminology rather than a new art

of healing. We must not claim too much. Psychology is not yet an exact science. Neither is medicine. It is much more of an art than a science. Very many useful discoveries have been associated with the names of eminent people, but it is very necessary we should keep before us all the while the wellbeing of the citizen, and not make the citizen the plaything of queer ideas, and that we should strive to re-establish normal social contacts, and not see things that are not there. In all this search for the abnormal sometimes the normal is overlooked, and what we want to do is not to discover how much the patient is out of his environment but how much the patient can be adapted to his environment and made to feel at ease in it.

I hope you will forgive me for these *obiter dicta*, but I am a little frightened by some recent developments, whereby some branches have made claims that are not justified by the body of ascertainable and verifiable facts available.

One important part of the work in which you are engaged is that there should be assistance given to people who have defective children—that there shall be visits, that they shall not be left in isolation but given as much help as possible, because I am satisfied that a very large number of citizens in this country now in the category of hopeless defectives could be made normal members of the community if continuous and sympathetic contact is made.

May I say this in conclusion: I doubt very much whether there is any better tribute that can be paid to a community than to say that it is a community where sympathetic care, organised care, tender care for people suffering from mental distress is available in some form or other. In the very recent past these were neglected, the poorest victims, the most cruelly treated victims of society; but we have now created a social conscience. Indeed, your present and your past activity is evidence of the existence of a social conscience. It is up to us to create a social machine to give that conscience effective expression in terms of treatment. I therefore very much felicitate you on what you have done. I can assure you we shall look forward to happy co-operation in the future, and that the Minister of Health will hope that in the years that lie ahead your endeavours in this field will be even more fertile than they have been in the past.

Community care in relation to the extended powers of Health Authorities under the National Health Service Act, 1946

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“Community care” is a term chiefly used in discussing mental deficiency. But I shall take it to mean in this context all the activities for furthering mental health that are carried on outside institutions, whether they are mental hospitals or institutions for defectives. The dividing line between community care and institutional care has, however, steadily lost its sharpness and become harder to see, since we have grasped that the illness which brings a man or woman into hospital is not an isolated episode, a drama played out on a private stage, without social causes or social consequences. Our concern about the patient who is in hospital causes us to take practical steps to prepare for his return to the community or to help his family to adjust to the gap created by his illness and absence: the steady increase in the number of psychiatric social workers on the staff of mental hospitals testifies to the growing appreciation of this need for community care, if I may put it that way, of the patient who is still in hospital. We look behind and we see our hospital patient at home and at work but even then needing help for his malaise: we look forward and we see him again in the community but perhaps unready to dispense wholly with the support we can afford him. It is now, therefore, rather artificial to make a sharp distinction between community care and institutional care, except for those patients who have a lifelong incapacity or handicap, for example, mental defect which will permanently take them out of the community. But for convenience I shall leave aside consideration of the community work for patients in hospital, while insisting that this is an important and essential part of mental hygiene.

The administrative measures for ensuring good community care are obviously going to be intricate, in their application to the varying conditions in different regions. The broad terms of the National Health Service Act will have to be translated into medical officers of mental health, professional staff, advisory bodies, and other agents and channels of policy. I shall not, of course, attempt to state what these administrative measures might be. But it is impossible to refrain from deploring that the

authority responsible for community care will usually be a different authority from that responsible for hospitals and clinics : whatever the advantages of control by the smaller local authority where community matters are in question, it will perpetuate some of the divisions and gaps of which we have painful experience in the mental health service (which has long been to so large an extent a national health service in form). But the die is cast : and what we must now hope is that the same doctors, psychologists and mental health workers as are employed by the regional authority may also be able in appropriate instances to work for the local authority or local education authority, on a part-time basis ; this would ensure continuity of personal care for the patient, and would serve to avoid his being provoked, or put off, or overlooked, because the people who help him about some of his intimate affairs at one stage of his illness have to hand over to somebody else at the next stage, though the problems are the same, and it is the same illness throughout. And, in a crude example, it is regrettable that those who ascertain, i.e., investigate and diagnose, are a different set of people with slightly different outlook and different organisation from those who treat the illness. However, this difficulty is not peculiar to mental health, it arises in other fields, and especially in regard to child health. No doubt much elasticity will be called for in the arrangements, not to speak of elasticity in the minds of those who make them.

The aim of community care will be as much preventive as therapeutic. But here, also, too sharp a distinction is misleading. Treatment of the sick child may be the means of preventing sickness in the adult : treatment of an incipient disorder may prevent the development of a chronic disorder. Rather than contrast prevention with treatment, it is more profitable to distinguish between measures devised for the community, and measures that are devised for the individual, taking account of his special circumstances : stressing the difference that there is, for example, between the public attack upon venereal disease and the individual effort made to examine and, if necessary, treat the apparently healthy wife and children of the patient who has been discovered to have, say, syphilis of the brain. Individual attention can be preventive, of course, and attention to the public at large can be therapeutic, but it is obvious that, as in other branches of public health, prevention will be dependent in the main on large-scale measures, based on certain knowledge of causes.

The systematic presentation of what community care ought to be has been set forth, with great clearness and force, by Dr. C. P. Blacker in his report on Neurosis and the Mental Health Services. His recommendations, supported as they are by

much factual evidence and by the general consent of all those closely acquainted with the problem, constitute a programme which ought to be the *vade mecum* of those who execute and the Bible of those who plan the mental health services. I shall make no effort to repeat his conclusions here. No doubt most of you are familiar with his account of the facts his Survey elicited, and with his argument and his practical recommendations. The National Health Act provides the means whereby such recommendations as his could be made actual as a national psychiatric service of high quality provided that enough people of the right kind could be found to work in it. It will be concerned with the manifestly ill—the “neurotics”, the “psychotics”, the defectives: and with those others on whom the psychiatrist’s advice is more and more sought—delinquents and psychopaths who are plainly at odds with society. Children will demand much attention: Dr. Blacker has eloquently stated the preventive value of child guidance clinics and kindred services; much of the work done by them will be dealt with in accordance with the provisions of the Education Act. There will need to be here, however, as I have mentioned earlier, continuity between the diverse agencies concerned with the single task of maintaining health. And then, besides the young, there will be the mounting proportions of old people, in whom the likelihood of some mental failure or disturbance increases steadily with advancing years. I do not want to cry “Woe” about the implications of our demographic position, but there can be little doubt that the elderly will presently make up the largest number of persons who require psychiatric attention at any given time. It may even be that the demand for improved attention to their needs will drain away time and effort that might otherwise be spent on the younger members of the community—a dangerous situation, if it should arise.

The means whereby community care will be provided must vary from place to place in accordance with prevailing customs and social organisation; variations should also develop through efforts to work out fresh and better methods by experiments departing more or less boldly from orthodoxy and local tradition. There are some activities which exist now here and there, flowering and fructifying, but sparsely distributed, which should spread luxuriantly if the best harvests are to be attained from community care. Thus psychiatric out-patient departments, as the Neurosis Survey abundantly showed, will have to be more numerous, more flexible and more generously staffed; they will have to concern themselves more than hitherto with “following-up” their patients and utilising the social resources of the community to the full. The possibilities of furthering mental health in industry and education likewise exist but are not fully availed of; some people look askance at the more aspiring and con-

· fident claims made at times by the psychiatrist in these fields of education and industry: but, even if his more ambitious offers and promises are put aside, there are still many ways in which his experience will enable him to be helpful, as the orthopaedic surgeon or the vocational psychologist can be helpful, for the school child and the worker. In speaking of what the psychiatrist may do I do not wish to imply that he can do his work in isolation, or that he alone can apply those principles which are beneficial in dealing with psychological malaise wherever it occurs. The general practitioner and the industrial medical officer will continually be handling such matters, so that the health centre and the industrial clinic will do effective work in preventing and treating psychological troubles—troubles which, if not overt, are so often incidental to, or behind, the physical ills that bring the patient to a doctor. The role of the psychologist, the psychiatric social worker, the nurse, the health visitor, the personnel manager or welfare officer, and many other brings them constantly, in varying degrees, into the circle of those providing community care for the mentally ill.

There is one form of community care which seems to be neglected. I cannot believe that "boarding out" is as fully employed as it should be for our patients. It is true that it is much used for the mentally defective but, apart from Scotland, this country has not shown as much enterprise in using family care as has been seen in some other countries. The arrangements at Gheel in Belgium are, I think, inimitable; we could not hope to develop anything of that kind here. But family care, whether in colonies or in dispersed communities, has been successfully introduced and practised in France, Germany, Scandinavia, Switzerland and the United States, and there has latterly been a thorough exposition by Miss Crutcher of how such work should be conducted in a modern community in which it is an innovation. The difficulties in the way of family care for children, especially maladjusted children, are only too well known to those who carry responsibility for such activities, especially on behalf of Local Authorities: and these difficulties would at first daunt anyone who attempted to develop it for the adult mentally ill in a largely industrial population such as ours. But as Miss Crutcher has pointed out, the success depends on the amount of time given to this special task by the psychiatric social workers—and to a lesser extent the doctors—of the mental hospitals and institutions: preparation and material support given to it by those who control the policy of the mental hospital and mental health service generally. It is at first sight expensive if properly conducted; but it means, in the long run, an economy in the annual cost of mental health services, and, more important, it means for many incurable patients an increase in the happiness with which they

can live, despite their handicaps. I hope very much that, in spite of the great obstacles, those in charge of the mental health programme in the various regions will make the most of family care for the mentally disordered and defective—which incidentally often makes it possible to utilise the experience of mental nurses, among others, who have given up nursing when they married and set up homes of their own.

The large number of patients referred by civilian agencies to the mental after-care service provided by the National Association for Mental Health during the war and since indicates how insistent is the demand for community care. Hospital almoners and doctors, D.R.O.s and other officials of the Ministry of Labour, social agencies and general practitioners have all asked that the mental after-care officers should deal with the manifest social difficulties of their mentally disturbed patients (among whom I include the neurotics); during the last twelve months 5,500 cases have been referred. There could be no more striking illustration of the need for a national mental health service, such as the new Act will provide, working on a regional basis. Nor, paradoxically, could there be stronger evidence than this of the incompleteness of our existing psychiatric community services, seeing that the mental after-care service has been a war-time makeshift scheme, not linked up organically as it should normally be with the health services of the regions and chronically unable to find sufficient skilled staff for all the work that it is asked to do. Clearly there will have to be an economical use of our present resources in trained people, enabling the social workers of each region to be attached to the mental health service of that region, both in its intra- and extra-mural activities. There will be great need in this for harmonious contact between the local authority and the regional health authority to ensure that there are not a number of separately organised groups of people in each region covering essentially the same ground. Whether the very considerable community activities of the National Association for Mental Health are linked mainly with those of the local authority or the regional authority, they should, in any case, in my judgment, be a part of the health service rather than a separate social service or part of the social services provided by the authority. This would also be true where the community work of the National Association and of other voluntary bodies has been asked for or promoted by the local education authority, the officials of the Ministry of Labour, or the Ministry of Pensions. There are, I know, strong arguments for keeping certain health services for the present within the administrative control of other departments than the Ministry of Health; but so long as our present shortages continue, it is surely unwise to dispose a comparatively small army of medical social workers (and, for that matter,

psychiatrists and psychologists) to provide isolated services for a number of different Ministries when, rationally regarded, they are an intimate part of the health service and could be much more economically used if organised as a single service. But this is a matter for administrative adjustment rather than for pronouncements.

In thus referring to our limited manpower in doctors, social workers, nurses, and so on, I have brought up a general topic which I think we must consider on such an occasion as this, viz., the limits set to what we can hope to achieve within the near future. There are in the main four limiting factors, and it is perhaps useful to face them in order that we may not fool or frustrate ourselves with excessive hopes. The four limits, as I see them, are set by (1) the number of available people, (2) the state of public opinion and knowledge about mental health and disease, (3) the state of expert opinion and knowledge on the subject, and (4) the intimate dependence of mental health upon the social fabric.

The first of these limiting factors, manpower, is seen in all the professional groups concerned. There is a dearth of psychiatrists, a dearth of nurses, of psychiatric social workers and psychologists, and, I think, a dearth of general practitioners with the requisite knowledge of psychiatry. The remedy for these shortages is to be found partly in improved recruitment, I suppose; but, with the overall manpower difficulties in the country, economical use of the people already in the field and the better training of those who are now entering it seem more likely to yield the necessary staff for the National Health Service than competitive efforts to induce more young men and women to enter upon one of these careers.

Further training of psychiatrists so that they may be ready to undertake the varied responsibilities of out-patient or community care of patients, including children, is actively in hand. The way was smoothed by generous provision made by the Government for subsidising the continued training of specialists who had been in the Services and, as the Goodenough Committee recommended, the essential need is being met—I mean the training of those who will be able to teach others. We may look forward to the time when in each Region there will be besides the University psychiatric department and associated with it, a mental hospital and clinic and a mental deficiency institution specially staffed so that they can receive the postgraduate entrants into psychiatric work and provide them with thorough clinical training and experience so that these newcomers, when they move on in due course to the other mental hospitals and clinics of the Region, will be able to carry out sound and comprehensive measures of treatment for all the sorts of mental disturbance

which may occur, in out-patients or in-patients, children or adults, as well as to handle preventive aspects of their work—advising on the many problems with a medical bearing which patients and their relatives bring, about marriage, work, children and so forth. As long as we pursue the policy we have hitherto followed, viz., letting newcomers into psychiatry start in any and every mental hospital which may have a vacancy so that they receive their main post-graduate clinical training more or less haphazard there, we will be falling short of the opportunity now opened up.

Psychiatric social workers present a rather different problem in that the now inadequate supply of trained persons is due far more to insufficient applications from people of the right quality than to any lack of facilities for training. To lower the high standards of selection (thus permitting a larger entry of students) or to abbreviate their training, would be a dangerous if not catastrophic way of coping with the scarcity: a psychiatric social worker has so much responsibility that people poorly equipped either in character, intelligence or technical education do much harm in this profession. The chief need then is to attract into it enough suitable recruits for the training centres at the various universities.

As for the general practitioner (who is often, of course, skilful in dealing with psychiatric problems, in spite of the meagre attention devoted to the subject during his training): his opportunity for covering this side of his work will, one hopes, be enhanced by the specialisation of function possible in health centres. But the chief improvement must come from the medical schools which, so far as psychological medicine is concerned, in past years have provided the student with stones rather than bread—a few heavily rationed stones rather than a sustaining amount of psychiatric bread. Here, however, the lesson has been driven home in the last few years and the recommendations of the Goodenough Committee are already bearing fruit: there is good reason to believe that for the large group of mentally disturbed patients who are not in mental hospitals or kindred institutions there will be available on the part of the medical profession in general as good a fund of skill and knowledge as there is for physical ailments, allowing for the differences in our state of knowledge.

*The second limiting factor I mentioned was public opinion. By this I mean the beliefs, and particularly the mistaken prejudices and fears prevailing in different sections of the community. Mental illness has so long carried a slur or threat. Mental hospitals have been regarded as anything but asylums in the literal sense of that word; patients gravely handicapped by “nerves” have received scanty sympathy, or, on the other

hand, excessive sentimentality has determined a faulty attitude of condonation and indulgence towards some of their conduct. The psychiatrist is often credited with Svengali-like qualities, or is discredited because he cannot achieve magical cures. I need not retail the well-known fancies and fairy tales which militate against sensible action: they are fortunately dwindling and dissolving in many places, but there is still much room for enlightenment. Different sections of the public have different failings, and therefore different needs in this respect. An ambitious plan for educating the public by means of explanatory lectures to lay audiences is not to my mind the best way of attaining this. Indirect methods seem to me more efficacious, working through teachers, doctors, the clergy, social workers, health visitors and others whose advice is sought and trusted. A comprehensive programme of health education soberly planned, can do much but if it overleaps itself, as can easily occur where emotions play the prominent part that they do in psychiatry, it can do harm.

I mentioned the state of expert knowledge as another limiting factor. We do not now know so much that we can forthwith demand the institution of a full service which will meet the community's psychiatric requirements in a way acceptable to all who are entitled to express an informed opinion. What Dr. Blacker, for example, has recommended constitutes a large, and I think an agreed, programme, which could provide an admirable service, a pattern for other countries. But it would still fall short of what some psychiatrists consider ideal, and attainable. Psychoanalysis, for example, is a method of treatment, on the scope and efficacy of which there is not yet unanimity. It is a time-consuming method of treatment, and costly: if it were used as widely as some doctors would think desirable the expense would be heavy, many more people would have to be trained to carry it out, and there would for a considerable time, as was recently pointed out in a letter to the *Lancet*, have to be decisions—about priority for this treatment—which would be decidedly awkward to make. There are doctors, on the other hand, who hold that the range of effective psychoanalytical treatment is so limited that it would not be reasonable to require a National Health Service to make this method of treatment widely available. I am not, of course, here concerned to examine the correctness or otherwise of these opposed views, but only to point out that an elaborate method of treatment which has been long used and is reputable may yet be to such an extent subject to varying opinion about its usefulness that the administrators of a health service might have difficulty in deciding whether and to what extent the treatment should be available in their region. This is a practical issue. It would

not answer to say that the public demand will settle it, or that doctors must themselves have the final say in recommending or carrying out the method of treatment they consider proper: the economic aspects of such lengthy treatment cannot be pushed aside, so long as the range and efficacy of the treatment is in dispute. Of course, once the application and value of any therapeutic method is generally accepted as proved, the treatment must be provided in the National Health Service whatever the cost, just as, say, expensive surgical attention is provided; there is fortunately no longer I think any need to argue the main question (i.e., adequate provision for psychiatric treatment in the community) on a bigoted financial basis: the cost to the country through mental ill-health, whether it lead to invalidism, absenteeism, crime or lengthy hospital residence, is so vast on any estimate that effective remedial or preventive measures could not be regarded as extravagant even though expensive.

There are many matters in psychiatric diagnosis and treatment besides the value of psychoanalysis which likewise demand further study and more certain knowledge or that we are quite dubious about the effect of the methods of treatment we employ. But I hope that nothing I have said will be taken to imply that we are mostly working in the dark, burrowing like moles, and flying like bats in the twilight. The statistics of psychiatric treatment, and the individual experience of psychiatrists and others in contact with the work, provide evidence very much to the contrary. But, as in other branches of medicine, we must look to research to increase our limited power to avert illness and to check it and mitigate it: and where we are dealing, as the psychiatrist is, with most complex influences and phenomena difficult to measure, we cannot readily arrive at the precision open to us through research and experiment in other branches of medicine. It is often said that if we were to use to the full the knowledge we already have, an immense improvement would be attained without any further research or discoveries. No doubt: but in mental illness there is so much misery that cannot be removed, and so many obscure problems that we cannot rest content where we are or forget that the development of the service is limited inexorably by the extent of our certainty about causes and ways of mastering them. This, of course, entails not only clinical or applied medical research, but also research in the related sciences, psychology, sociology, physiology and biochemistry, not to speak of genetics.

There is another kind of knowledge which must be gathered systematically if we are to profit by accumulated experience. No service can be planned without information about previous trends and effects: this information can be got only from regular statistics. The number of hospital beds needed in the next and

succeeding decades, the staff necessary for clinics, the appropriateness of certain methods of treatment commonly employed, the natural history of diseases—none of these things can be known for sure without statistical analysis of reliable data. Latterly we have lagged behind some other countries in the publication of such material, and, I think we have lagged also in the unpublished collection and analysis of it.

Now, as to my fourth limiting factor. Public health is always intimately related to the social conditions of a country. This is more strikingly evident in psychiatry than in other branches of medicine; it would not be far-fetched to say that the amount and kind of mental disturbance in a community is a fair index of whether its social organisation is sound and healthy. Consider, for instance, how the amount of mental ill-health due to alcohol has diminished during the last 40 years in England: and this not because of any direct effort by health authorities, or discovery of any medical panacea, but because of the alteration in the social milieu and habits of the people. Nor is it only as a cause of mental health or ill-health that the social background is to be viewed, but also in its bearing on treatment. There are still many changes to strive for in our social fabric which will give security and stability to people's lives in their material and their immaterial aspects, and thereby make possible much more effective treatment of the sick. Much may be expected, as indeed much has already been demonstrably achieved, through the changes in industry, which have lessened the stresses and friction there. The machinery for dealing with rehabilitation and resettlement of disabled persons has made the task of the physician at once heavier and lighter—heavier since he has to attend to matters which often in the past he overlooked, lighter in that he can now do much more to restore his patient to normal life and wellbeing, with the co-operation of the D.R.O. and the others concerned in this invaluable procedure. Nothing would be easier than to pile up instances showing how social agencies can help in the work of restoring to health the mentally ill in the community. But few would dispute the existence still of many defects and ills in the social structure; these defects and ills arise, it is true, largely through the individual failings and ailments of those who make up the community, but they are also a heritage from the past amenable to direct attack, or, at any rate to attack; they are not walls of Jericho, perhaps, but still far from impregnable. And while they stand they undoubtedly restrict what one can sometimes do for one's patients.

I have been stressing the limitations upon what can be achieved in promoting mental health in the immediate future: these limitations, however, seen from the other side offer many openings through which improvement may come. Doctors and

other professional workers may still be too few but more and more are being trained; the public is growing in its understanding of what mental health can mean; knowledge is being quietly, if too slowly, increased by study and research; and in some ways social pressures are being eased. The new Health Act affords an opportunity for advancing the mental health of the community greatly: it will be our fault—or the Minister's—if we do not seize it to the full.

DISCUSSION

Dr. The Hon. W. S. Maclay, O.B.E. (Senior Commissioner, Board of Control) : In the few minutes at my disposal I can only touch on one or two of the points arising out of Professor Lewis's address, and on some of the hopes and fears that have been running through my own mind.

Early in his paper Dr. Lewis said with truth that, whatever one's own views might be, the die is cast and the various aspects of Mental Health are not all going to be in the same hands. This may lead to difficulties. I have no doubt that the difficulties could be easily solved in a world where everyone was perfect, but unfortunately we must try to make the Mental Health Services run smoothly and efficiently in a world which is as yet imperfect, in spite of the efforts of the Minister.

Under the National Health Service Bill it can be anticipated that in each region there will be a Mental Health Committee of the Regional Board with a Medical Officer of Mental Health, but there will also be Mental Health Committees of the Local Health Authorities. It is, as has been said, vitally important that these two Organisations should work in close co-operation and should make use of each other's officers. Let me mention one or two instances in which, to me, close co-operation seems especially important. It is the duty, or will be the duty, of the Local Health Authorities to make the arrangements for sending patients to Mental Hospitals. Duly authorised officers will be appointed to do the work previously done by Relieving Officers. We do not know yet where these officers will be recruited or what training they will receive, but I do hope that they will make full use of the duty laid upon the hospital and specialist service to supply specialist advice in the home if required. I do not suggest that a psychiatrist should be called in to every case, but we all know from past experience that there will be many occasions when the duly authorised officer should—and we expect will—welcome the advice of the psychiatrist, advice which was not officially available to the Relieving Officer in the past.

The actual transfer of a patient to hospital can be to the

patient a very alarming and frightening experience. The mode of transport and the care given during the journey have varied greatly in the past and have not always been satisfactory. My own feeling is that these patients should be attended by trained nurses, and that the most satisfactory solution would be if the transport and nurses could come from the hospital to which the patient is going. They would thus get expert attention from the earliest moment.

Let me turn for a moment to mental deficiency. The ascertainment of defectives will be the duty of the Local Health Authority. Now when the case comes up for discussion, will the Committee get advice from an officer of the Local Health Authority or will they use a psychiatrist from the specialist service? I hope the latter. But even more important, it seems to me, is to ensure that if certification be required then one at least of the two certifying doctors should be from the Hospital service. In this way it would be possible to get harmonious co-operation and the best advice, and to avoid the friction that might easily arise if, for instance, one of the authorities preferred not to send patients to institutions and another almost invariably sent them.

Then there is the difficult problem of after-care. The Local Health Authorities will have a variety of staff to carry out their duties of home nursing, health visiting, etc. Will they have trained psychiatric social workers as well? Even if they do, it is quite clear that the hospitals and out-patients departments will require their own psychiatric workers. Does this mean that there are to be two sets of social workers, one employed by the Regional Board and the other by the Local Health Authority, with the danger of different standards; or does it mean a common pool for the use of both? If the former, which Authority will be the employer? If the latter, how will you get over the danger of divided loyalties? Whatever method is adopted, there is the danger of overlapping and of too many people dealing with the patient, or of the patient falling between two stools and nobody dealing with him at all. I would make one suggestion which I think is a practical one. That is, so long as a patient is attending a clinic as a psychiatric out-patient, even if only at long intervals, then that patient should be under the care of the social worker attached to that clinic and should only be passed to the care of the Local Health Authority when specialist medical treatment is no longer required. In this way at least some continuity in the care of patients could be achieved.

I have purposely confined myself to what may seem matters of detailed administration, but it is on the successful solution of such problems that the success of the service will depend.

I am confident that the problems can be solved; I only hope that the welfare of the patient, and not administrative convenience, will be the main consideration in finding the right solution.

Dr. Thomas Beaton, O.B.E. (Medical Superintendent, St. James Hospital, Portsmouth): Working in a limited area, that of the County Borough of Portsmouth, where it has been possible to explore the potentialities of a comprehensive Mental Health Service covering all the fields from Child Guidance and Delinquency, Mental Deficiency, Neurosis, Psychosis and Senility, one is nervous as to the effect of the New Health Act in separating the domiciliary from the hospital service. In no other branch of medicine is it so essential that the specialist should be on the scene from the word "go", and that the patient should be handled consistently throughout, whether in hospital or at home, under one authority, and by specially trained personnel.

The merging of all extra mural work into the general Health Service of the Local Authority is a step which may easily result in the failure to give sufficient regard to the very special problems of Mental Health, and much mischief may arise. Patients are liable to fall between two stools, as can happen now where there is no unified attack on the problem, and there may be much loss of time and drift.

I was hoping to hear from Dr. Maclay that some of these difficulties were being resolved and I am the more anxious after listening to his review of the position. I feel myself that though Local Authorities may have the responsibility for providing domiciliary service, they will have to use the hospital specialists provided by the State. I cannot envisage enough experienced medical and nursing personnel to supply two separate services. Apart from the limited number of psychiatrists available, the provision of experienced mental nurses is a very acute administrative problem at the present day. The general trained nurse is accustomed to deal with patients who obey her orders, who co-operate with her and who grasp the point of the treatment which is being applied. She expects to see quick results one way or the other. The mentally trained nurse, on the other hand, is trained to handle patients who often do not understand, who do not co-operate and will try sometimes to undo any good that has been done. The whole approach is vastly different in the two spheres of work. How the Local Authority is going to provide proper attention by trained mental nurses apart from the hospital staffs I cannot imagine.

There is also the question of the Psychiatric Social Worker, who, working in a comprehensive Mental Health Service, is the link between the home and the hospital. In Portsmouth there

are five, three of them fully trained, and they are all fully occupied.

If there is to be this complete division between the Local Service and the Hospital Service, there will be either duplication or a lack of consistent handling. I can only hope that when the new Act comes to be implemented the Minister will see to it that the liaison between the two services is the closest possible, and that in carrying out their responsibilities the Local Authorities will have the full use of the Hospital specialist personnel, medical, nursing and lay.

Reference has been made to the Relieving Officer who one can expect will become the "Appointed Officer" of the Local Authority. His has been a most difficult task in the past and I feel that he has been somewhat maligned. I can assure Dr. Maclay that in Portsmouth, ever since the passing of the Mental Treatment Act of 1930, the Relieving Officer has always worked in the closest touch with the psychiatrist. Often he has exercised his discretion and brought a case straight to the hospital for admission as a Voluntary Patient rather than follow the procedure of the old Lunacy Act, and not infrequently he has rung up the hospital for a medical officer to see the patient before taking any action.

The work at Portsmouth has shown that under the Mental Treatment Act a Mental Health Service can be built up with a complete liaison with all concerned. From my experience I do not think that a satisfactory result will be achieved under a duplicate system, and I can only reiterate the hope that the duties of the Local Authorities in regard to Mental Health under the new Act will be carried out by the Hospital personnel through the organisation of clinics and social service covering the areas which the hospitals serve.

Dr. Doris Odlum (Joint Hon. Secretary, Provisional National Council for Mental Health): The new Act will afford unprecedented facilities for the work of Local Authorities in the field of prevention. The vital importance of treating cases of nervous and mental disorder in the early stages is now fully recognised. We are beginning to realise that there are two definite types of people, who may be described as the tough and the tender. The tough are able to stand up to the difficulties of life and only show a passing emotional disturbance if they are faced with exceptional strain. The tender, however, are much more sensitive, and life to them is always more difficult. If they are subjected to strain they do not recover easily unless they have special help. Moreover, they are not so adaptable and consequently need to have a suitable environment and suitable type of work if they are to fulfil their potentialities and be

useful members of the community. Under favourable conditions they can be extremely valuable and do good work, indeed many of them hold high positions and make a great contribution to our national life. But if through any unfortunate circumstances, or through their lack of confidence in themselves, they develop anxiety symptoms or a feeling of inadequacy it is essential that they should get help in the earliest stages. If they do get this help they respond most favourably, but if they are not treated in the early stages they very soon deteriorate and become a prey to permanent loss of confidence and anxiety which makes them quite unable to carry on. These are the people for whom an out-patient department is especially important, and now all Local Authorities have an opportunity to provide this help by setting up adequate out-patient clinics. It is essential that such clinics should be staffed not only by psychiatrists but also by psychiatric social workers who can help to deal with the patients' social and domestic background, and also help them in relation to their employment. It would, I think, be true to say that at least 50 per cent. of the value of an out-patient department lies in the psychiatric social worker. I am well aware that under present circumstances one of the greatest handicaps that Local Authorities will meet in trying to start clinics is the shortage of personnel. Neither psychiatrists nor psychiatric social workers can be trained in a day, but if there is a firm demand we shall in the course of the next ten years be able to produce an adequate supply of experts. It is for the Local Authorities to make sure that they create the demand. It is obvious that in the reconstruction of the post-war years we are going to need the maximum contribution of every single human being in the country; and, apart from the suffering involved, we cannot afford the loss to the community that would be entailed by carrying a dead weight of preventable neurosis.

Baillie John Porter (Renfrewshire Education Committee): As a member of a Local Authority, I would like to put our side of the problem before this Conference. A Local Authority is called upon to provide up to date health services. No member of a Local Authority would have any objection to providing the very best for those who require attention, but in order to provide specialist continuation of treatment, funds are necessary. We have to administer for people in great difficulties and have not the power to do so because of our limited resources. I would like to feel that some machinery will now be created whereby that difficulty may be overcome.

Dr. C. Davies-Jones (Director, Isle of Wight Mental Health Services): I have come from the Isle of Wight which

is very close to Portsmouth, but in no sense to steal its thunder. There, in a small circumscribed area of about 90,000 inhabitants, largely rural and with none too good transport facilities, it still appears to me unnecessary to paint too gloomy a picture in regard to the future working of the National Health Service Act. I feel strongly that so much in this Act is for the benefit of the community that it behoves all to do their level best to endeavour to administer it. If your personnel have the guts you will do it. I can remember the time when there was one voluntary patient in the Isle of Wight County Mental Hospital; now nearly three quarters of the admissions come on a voluntary basis and only about a quarter are certified. True, the Hospital is a small one, consisting of nine wards, and out of these only two are now locked. Here is an indication that, given the right personnel with the right attitude, it can be done. In the Island we have The Child Guidance and Mental Deficiency Centres all under one Directorship, but here again its success is largely due to the hands which help. With regard to the Relieving Officer, I have always felt that he is a person taking a lively interest in Mental Health work, and my own experience shows that he keeps well in touch even to the extent of consulting at the Clinics when necessary.

When I first came to the Island no clinics of any description were held; now we have four sessions weekly, and find that it is better to have these sessions dispersed throughout the Island. For example, one is held in the Mental Hospital, one in the General Hospital, one in a Borough Town Hall, and the remaining one in a Nursing Institute.

Alderman H. J. Bambridge, O.B.E., J.P. (Yorkshire Mental Hospitals Board): Dr. Maclay and Dr. Beaton both rather deprecated the division of responsibility. I hold the contrary opinion. We heard this morning and this afternoon of the reluctance of people to use the clinics that are provided and will be provided under the new National Health Act. I think there is a danger that you may possibly try to separate this problem from other problems that are dealt with under the Act. Let us bear in mind that all speakers have agreed that there is a reluctance to use clinics and this problem does not differ from others in this particular respect, that early diagnosis is of very considerable importance. Then how can that early diagnosis be best achieved? I am suggesting that it might be better achieved through the agency of the local Health Authority than through the hospital. Under the hospital scheme you will have large regional areas. My particular Health Authority is probably one of the nearest approaches to a regional authority for all the purposes connected with preventive medicine which

the authority will have to undertake, and it is setting up an organisation for preventive medicine in every one of the areas for which we are responsible. Surely that organisation is the most appropriate organisation for getting into first touch with this difficult problem, particularly with young persons. When your regional organisation has been speeded up in 1948, you will not have clinics available for the remotest parts of the area covered by Local Authorities, but you can have, and will have, particularly in my part of the world, at any rate an organisation which will be in touch with the remotest parts of the county, and will have medical personnel available for the care and protection and examination of school children. Now, in addition to the local organisation operating on behalf of the central county organisation, you will have attached to it, not only for the purposes of this particular Conference, but for all the problems that can be dealt with, a specialised staff which will be available for all the county area. When you get that, then you will be getting in touch with the early case. It comes within the ordinary course of public preventive medicine service, operated through the ordinary Public Health Department. I do not know and have not heard of any more practical way of coming into contact with the young people and with the people who are reluctant to use the clinics provided by the hospitals. It seems to me that, given ordinary common sense, when you have got to that stage there will be no difficulty whatever in achieving the measure of co-operation between the Public Health authority dealing with its general problems and the individual problem; there will be no difficulty in establishing a co-operative machine between it and the hospitals, whose problem it will become.

Miss R. S. Addis (Regional Representative, Region 12, National Association for Mental Health): I would like to join other speakers in stressing the importance of early treatment, early contact with the case (or what is going to be a case later on), from the social worker's point of view. Much has been said this afternoon about the importance of social workers specialised in mental health to stimulate all of us to fresh efforts. We feel very strongly that we have an important part to play, and want to enlarge our field and to improve our work in many directions. From the social worker's point of view, I think one of the most important sides is the contact not only with the individual patient at an early stage but with the family—meeting the wife, meeting the husband, meeting the parents, going into the home. It is as a visitor to the home, getting into contact with the different members of the family, that social workers can do a great deal to prepare not only the patient himself for treatment, but to prepare the family to accept

the necessities of treatment, and perhaps, if need be, to accept the handicaps which the patient has to bear.

The After-Care Scheme, for which I am working, grew up in the war as an emergency scheme. Representatives all over the country have had to deal with the Mental Health Services as they found them, and they vary greatly from one area to another, as we all know. Although we have worked in very different conditions, I think my fellow workers will agree we have learned certain lessons, however different the set-up with which we are working. We know this is one of the most important tasks, this necessity for personal contact with the patient and with the family at an early stage, so that, if necessary, he may be prepared for treatment, and his family to accept it, or helped during treatment and after treatment to regain his complete independence.

This leads to one further stage which I would like to see considered as a necessary part of Mental Health social work: that is the preventive side where we try to find not only the early cases—which may never come to a hospital or clinic—but to carry into the community the Mental Health principles which we learn through our work. We have contact with those who are in charge of children, with those running homes for children, as well as with welfare work for adults. In every different branch of work we carry out those ideas founded on Mental Health principles.

Dr. E. Cunningham Dax (Medical Superintendent, Netherne Hospital, Coulsdon, Surrey): I think we ought to make some concrete plan for dealing with elderly patients. I thought it might help the Conference if I gave one or two figures to show the extent of this problem. Out of something like 1,000 patients a year, we at Netherne have 250 patients over 65. Approximately one in six of those die within a month of admission, one in four within three months, and one in three within six months; but out of the people over 65, about 45 per cent. are discharged.

Dr. Felix W. Brown (late Acting Medical Director, York Clinic, Guy's Hospital): I want to make a plea for treatment to be provided for a special and very common type of patient, whose needs I was glad to hear mentioned just now by the Minister of Health. I refer to the patient one sees in Out-Patients' Departments who needs In-Patient treatment, who is uncertifiable, who is not willing to enter a mental hospital as a voluntary patient on account of the stigma, and yet who is very definitely asking for help. It is perhaps unreasonable that such patients do not wish to enter a mental hospital, but there is no doubt that the mental

hospital to the ears of the general public carries a certain stigma. These patients would be willing to enter a general hospital. At present there are no facilities for them in general hospitals. At Guy's there is a department, but it is not yet available to the hospital class of patient. Both the general and the psychiatric department benefit by the close association of psychiatry with general medicine, from the point of view of both teaching and treatment. Efforts are being made in some hospitals in this direction, but on not nearly a large enough scale, for there is a vast need for in-patient facilities for psychiatric treatment in general hospitals for patients who are not suitable for mental hospitals.

Councillor Dr. Z. P. Fernandez (Chairman, Leeds Mental Health Services Committee) : The only reason I wish to speak is because I happen to be a Medical Councillor of sixteen years' experience. I also belong to two Joint Committees dealing with mental deficiency and mental diseases. Recently, we in Leeds and West Riding appointed a Professor of Psychiatry, because we felt anyone holding that Chair should have a general knowledge not only of psychosis but of the other allied problems. There has been too much emphasis on the psychosis and not enough on psychiatry and neurosis from doctors experienced in mental diseases. In the hospitals of the future the Minister is anxious to fuse both the physical and the mental work as in the new Act. In dealing with the community problem, the Local Authority still has to deal with these independently, in many ways, of the machinery of the past.

In the City of Leeds we are rather proud of our work in dealing with the Mental Deficiency problem. We were able to develop centres for training and we felt, as an independent authority, that we could settle many problems. Joint authorities of two or three million population in my opinion will be unworkable so far as local care is concerned. Local authorities will still control aspects of mental problems through the education committee and the child welfare committee.

I hope the Association will stress that the new machinery set up should be responsible to popular control. We should insist, in dealing with these problems, on the closer relationship of general physicians and mental health physicians. This Association should go forward in uniting these new authorities, so that there will be a national body to see that mental health is properly co-ordinated, and that community care is done through the Local Authority rather than the officials of a central authority.

Dr. Kate Friedlander (Director, West Sussex Child Guidance Services) : Dr. Lewis mentioned public opinion as one

of the limiting factors in an efficient Mental Health Service. I believe that a planned propaganda, based on social and psychological research, applied from the start would bear fruit in the long run. Although we do not know all the factors in early childhood which cause mental illness in later life, we know already that certain environmental factors are found very regularly in later neurotic disturbances. To take a concrete example—we believe that severe feeding disturbances in early childhood together with a number of other factors may cause undesirable disturbances in later life. We therefore want to influence the public so that such feeding disturbances will be avoided, quite apart from treating these at the earliest moment.

Mrs. H. S. Anthony (Psychologist, Somerset County Council): A valuable aspect of community service to mental health is the work done by the psychologist working for a local Education Authority in the schools. By this means children requiring treatment at a Mental Health Clinic can be taken there, and the overloading of Child Guidance Clinics with low-mentality cases may be avoided. The formation of parent-teacher associations may be encouraged and used as a medium for the right kind of publicity for the Mental Health Services.

The Chairman: Much that we have heard this afternoon requires very careful consideration before one can say on which side the balance of judgment lies. We have had a fruitful discussion covering a wide range of subjects. I was struck by one sentence of Professor Lewis's brilliant paper. He hoped for elasticity in the arrangements and elasticity in the minds of those who have to frame them. I think that this afternoon's discussion goes to show that in framing the arrangements we shall have to avoid any temptation to apply a uniform pattern to all and sundry. This will need very careful working out; particularly in regard to the problem of the link-up between the hospital services and the community care services. Dr. Beaton was a little apprehensive that this problem was a long way from solution, but I can assure you that it is receiving active attention, because these arrangements must be worked out for the operation of the new Act in 1948.

There is one other point I would like to mention. I think we, all of us, noted with pleasure that two or three of the very experienced people who have spoken to us this afternoon spoke with what I believe Mr. Churchill would call "sober optimism" about the future of Mental Health Services. Therefore, I think we can adjourn this evening in good heart.

END OF AFTERNOON SESSION

FRIDAY, NOVEMBER 15th
MORNING SESSION

Chairman:

Rev. John H. Litten

(Principal, National Children's Home)

The Chairman: The Provisional National Council for Mental Health, in convening this Conference on the important dual subjects (for the two are not unrelated) of the Homeless Child and Juvenile Delinquency, has shown a very wise foresight in calling to the aid of this Conference two such understanding and sympathetic exponents of these central themes as Dr. Lucy Fildes and Miss Margery Fry.

May I be allowed to say, as one who for more years than he cares to count, has had the privilege of association with the practical care of homeless children and the conduct of approved schools for the help of the delinquent, that I wish, on behalf of those I am honoured to represent, to pay my tribute of respectful gratitude to the wise and strong leadership which Miss Fildes and Miss Fry have given in this country to all who are directly concerned with those primary problems which are before us for consideration in Conference this morning. They have shown us that our concern is not only with physical but with mental health and, in making more clear the causes of our problems, they have guided all those who daily have to concern themselves with the effects. What was a somewhat tortuous by-path has widened to a broad highway, and what was sometimes felt to be a kind of mystery cult for the few has become a working system for us all.

The thing which impresses me and distresses me every day I live is the frightful mess that is being made in the minds of children by the broken homes, the lost loyalties, and the ruined lives with which so many of these unfortunate homeless children have had to deal. Father, mother, home, security, love, friendship—the things that make the music of life—for many of them are dumb, or worse still, make discordant noises. To mend those broken chords, to adjust the warped mind, to resolve those discords into greater harmonies, are the subtle and delicate tasks in which our two principal speakers this morning have been our leaders, and we thank them. That all of us may learn to do these things ever more deftly, and with the touch of a master, carries with it, I am persuaded, the latent promise of the greater things that lie before us.

The Care of the Homeless Child

Lucy G. Fildes, B.A., Ph.D.

(Chief Educational Psychologist, London Child Guidance Centre)

When this subject was suggested to me for discussion I felt, and I am sure you will sympathise with my feelings, that perhaps at this present moment there is little more that could or should be said on the subject of the homeless child. On thinking the matter over, however, I did consider that, in relation particularly to this audience, it might be of value if something yet further were said and that for three reasons—firstly, that this is a meeting primarily for discussion and consideration of views, secondly, in this meeting there are very many people who will be instrumental, and probably primarily instrumental, in leading the country in new ways towards the care of the homeless child and, thirdly, because the new contributions to such care have come from that angle of knowledge in which we are primarily interested, namely, the angle of Mental Health. Therefore it did seem that it might be worth while my recalling to you certain general principles, which in view of modern knowledge must underlie the future of the organisation and treatment of the children now under discussion.

Before I begin on the question of general principles, I should like to pay tribute to those men and women, administrators and workers, who during the past thirty or forty years have done so much in this country for the betterment of the homeless child. One cannot review the situation as it exists to-day, and think back upon the situation as I first knew it, without realising the tremendous amount that has been done. I do not want you to go away thinking that because it is possible to make new suggestions we are in any way reflecting on the efforts of those who have worked so valuably in the past and who to-day, many of them, I am quite sure, are willing to do what is perhaps most difficult in human achievement, to give up an organisation and structure which has been successful in the past, in favour of new experiments in the light of new knowledge.

With regard then to the question of certain general principles, I feel that it is only by undertaking them that we can set about reorganisation in our own particular areas and in relation to our own particular setting—for no one here or in any other field of activity wants uniformity. No one can

say that this and that should be done. It rests with those, whose duty it is to make provision for these children, to understand their needs and to plan according to those needs in the best way to suit their own particular situation.

I come then simply to lay before you certain specific needs of children, that modern investigation has turned from what was perhaps implicit knowledge in some, to general proven knowledge which can be handed on to all.

The first point perhaps I can put to you best on the basis of an illustration. I remember in the old days, more years ago than I like to think about, that a family of children, an ordinary family, were excited and not only excited but rather perturbed and annoyed by the coming of a strange cat who stole their pet's food, who ran away when approached, who fought and injured their cat, who responded to petting with scratching and biting. And I remember still the statement made by the parents to the children by way of comfort and alleviation and understanding: "You see, he belongs to nobody." I remember, too, that to this same home a child came a little later on with an unfortunate history, a beloved mother long ill and then dead, replaced only too soon by a very young irresponsible and feckless stepmother, with the resulting desertion of the father. The children's relatives accepted the girls, but the boy was rejected as being too difficult to be taken by them, and he was taken into this family out of true charity but with a difference in attitude. Like the cat, he lied, he stole, he did not respond to kindness, but kicked and screamed, he ran away—and yet, how difficult to understand the child, while it was apparently easy to understand the cat. The child is naughty, he is dirty, he is destructive, he is tiresome. Above all, he is ungrateful for what he never wanted. Now this situation does, I think, put to us the meaning of what I tried to convey when I said that modern knowledge has made clear what was really implicit knowledge before in the minds of many people. Like the cat, the child belonged to nobody, and there we have the expression of the fundamental need of man, more particularly of the child, the need for belonging to somebody. Yes, and let us think how it can be carried out and perhaps we can think of that more easily if we regard it in the negative way. Think of a child aged 8, having already lived in 17 homes, having settled in one, living there for 9 months (which was the longest stay during his short life), moved from that home without notice, without explanation, again rejected. How can a child taken from its mother, placed in a nursery, left there till 2, placed in another home, left there till 5, placed in a further home until he is 14, and

then placed somewhere else until he is 18, have a feeling of belonging to somebody. How can a child placed in a home with 400, 500 or 600 children of his own age develop such a feeling? I put this proved principle to you for consideration in relation to the way in which you should understand and meet the needs of children.

Another point. Children need to be ordinary. Grown-ups do not like being considered not ordinary, for, after all, we know that there are few of us who like to dress in a way suitable for 40 years ago, or who would like to live with the facilities available of that time. We want to be within limits like our neighbours, and so do children. This was expressed very definitely I think by a remark made by a child whom I saw, a handicapped child born without legs, who had been kindly treated, adequately treated but who in early adolescence had expressed her one desire: "I should like to be a big girl." Now it is the realisation of that sort of thing that must control our decisions with regard to children. How can children placed in a huge group with a lot of other children of their own age be made to feel like ordinary children. How can children who go out for walks dressed in a peculiar uniform, walking in crocodiles, guarded by people at the head and the tail, feel that they are like ordinary children. Could you feel that you were an ordinary person if you lived in a house labelled outside "A Home for Friendless Girls", or if you lived in a community, the mere statement of your residence indicating that you were illegitimate? I ask you to consider these human things in relation to your children.

There is one further thing which I would stress that children need. That is the experience which will enable them to grow and develop and use their own minds, both their feelings and their intelligence, in the normal way. Now it has been said, indeed I have said it myself, that the majority of children deprived of normal home life tend to be tough. That may be so. In fact, in view of their history, it might be astonishing if this were not so, but I should like to point this out to you. It is becoming popular to make assessments of intelligence. Ask yourselves this—can you assess the intelligence of an individual who is so deprived of a normal "feeling relationship" in his life that his mind is occupied in trying to make up for that feeling relationship, so that he cannot use ordinary things to gain experience? Can you regard as having had ordinary experience a group of children it was my fortune or misfortune to see who were kept in a nursery and, in the main, kept in their beds, so that at the age of 2 not one could speak and only a few could walk and

all were stated to be mentally defective, at that early age, but who were later mercifully rescued from that environment, due to the exigencies of war, and turned by human understanding into a group of happy, normal (not, I will say, intelligent) but responsible, friendly children, not one of whom had the remotest signs of mental deficiency. How can children who are herded in groups, who have given to them from outside treats and toys, but who are not allowed to experiment with the simple things of the external world, be said to have a normal opportunity for development and learning. I have never forgotten a statement made by one boy, a difficult child, who had been excluded from an ordinary school for a year because he was constantly dirty and wet. He was placed in a home. He was removed from that home and on the journey his escort remarked to him: "This is the place where the boys play football." The boy looked at her and said: "Do they kick it?" "Why, of course," she said. He replied, "Our football is on the shelf." Only too often the opportunity for experience is denied to these children.

How could you assess the intelligence of a child who for 10 years had been in hospital? Perhaps few would attempt to do that, but I contend that in considering this point of testing the intelligence of the children it is impossible to make such an assessment unless you give these children happiness, opportunity for learning, the relief from mental stress and the real opportunity for play and experience.

I have suggested a few points which seem to me to be worth consideration in relation to the planning for children. There are many others, but I do urge, if you are going to plan, do not for goodness sake go to another authority and see what they do and follow their example or arrange something that is apparently little better. Think out from general principles what are the children's needs and consider how best those needs can be met in general. Of course, the implications of what I have said are that the nearer the children's situation is to that of the normal child, the more adequate and suitable is the treatment likely to be for them.

In closing I would say that I think the thing which impressed me most when visiting homes for children and in dealing with those who are responsible for their care, is the enormous variety in provision at the present day. The children may be housed in palaces, or something approaching palaces, they may be housed in dilapidated huts, they may be handled with what seems splendid human insight or there may be no relation to their real needs. Now that in itself is wrong. The fact that a child accidentally comes to a certain authority or a certain society for care, should not

mean this colossal difference in care. Two things are quite obviously necessary. The first is that the people who are going to be responsible for the care of the children must be people who have knowledge and insight into their needs. The other is that, in making plans and in considering schemes for the well-being of children, I would suggest that those who are in authority should consider very seriously whether the provisions they are to make are for the glorification of the authority, or for the good of the child. I have seen many places, beautiful buildings, provision of swimming baths, provision of gymnasia, provision of playing fields. It may be, and I sometimes think it is, that these things are provided for the well-being of the children, but let us think of our general principles—would not these children be better and happier in using the provisions made for the children in the ordinary community, so that they felt they were ordinary children. There is no harm, indeed there is much good, in making such provisions, but those are not the important points.

DISCUSSION

Miss Gwendolen B. Chesters, B.A.: In thinking in relation to each of the points Miss Fildes has made, I would like to suggest that we might give a little further consideration to the possibility of their application from the child's earliest days, and to the means of giving him a reasonable constancy of care from babyhood onwards. Babies have a need as great as that of older children for family life. They have an equally great need to be ordinary babies. They have an equally great need for food, not only for their bodies, but also for their minds; and the alternative to family life for babies can only be a degree of loneliness that is in any case a handicap to the growth of rich stable feelings and to the growth of effective mental activity. Severe breaks in continuity of experience must be avoided for all children. It is generally recognised that a break at an older age is very difficult. It has equally serious consequences for younger children. It involves them in a situation which amounts to total bereavement when the time comes for them to be transferred to an older group.

From the point of view of staffing there are various points to be considered. The staffing for a group of young babies only is not an easy one. The baby deprived of family life and placed in a group of babies must usually be cared for by young girls who are not yet able to give him mothering of a necessarily mature kind. A further point gives rise to concern on behalf of the staff. They have in many instances genuine affection for

the children in their care. The experience of those in charge of groups of young children cannot but impose considerable strain upon them. When the time comes for the transfer of the child to an older group, those who have had the care of him are required to relinquish him, no matter how satisfactory their relationship to him may be. Losses of this kind happen continually, and the adult has not only to endure such losses but has to be prepared to give a warm and friendly welcome to the newcomers who take the place of those who have gone. Along with the other difficulties inherent in the work, this constantly recurring experience of a disturbing kind tends to make the housemother's task of giving sound affection to the children almost an impossible one.

For these and many other reasons it is essential that life for babies should be so planned as to allow them normal opportunities of continuous care.

Rev. Wm. Hodgkins, M.A. (Rochdale Education Committee): I would like to bring to your attention the needs of three unfortunate groups of children. The first group of homeless child is that known as the spastic group, the children who suffer from cerebral palsy. They are nobody's children. There has been in the past considerable intellectual exploration and the time is ripe for a great deal of practical application. At Carshalton, the London County Council has been doing some very fine work; in Manchester at the Orthopaedic Hospital and the Children's Hospital, work has been going on for a matter of twelve years or so. We have sufficient knowledge now for a new set-up for these children. Yet they are still pushed from authority to authority. They pass out of the care, unfortunately, of the Education Committee, and, more unfortunately still, are often placed under the care of some County Mental Hospital Committee which is frequently inadequate and incompetent to deal with the situation. These children require specialised care in three different branches—mental, and physical treatment, and a full education. They require continual care from a year or eighteen months until their late teens. We have already proved through the work of the clinics in this country, and by the work of Van Assam in Holland, and Phelps in U.S.A., that many of these children could be salvaged and passed into the social stream, and become competent citizens ready and willing to serve the purpose and spirit of their generation.

We use the term ineducable in relation to two groups of children, idiots and imbeciles, and a more unfortunate term was never found. We label them as ineducable, and as a consequence they pass from the care of people who might be able to understand them and treat them adequately in proper surroundings

and in a sensible manner, into the care of County Mental Health Committees, which often means Poor Law Institutions. We have children in this country at the present time who are in the mental wards of Poor Law Institutions, and some who are at home, destroying hearts as well as homes, who are incapable in such surroundings of living a normal life. The suggestion that was made this morning was to give them normality. I agree, but it must be the normality fitted to the child's needs; and those who have seen the imbecile child in proper surroundings and have realised as a consequence that education is for the well-being of the child according to the norm of the child, appreciate that a great deal can be done. These children are the derelicts of our civilisation. It is a distressing situation which could be changed if we had the knowledge, and I am certain we could obtain the insight if we had the will.

Councillor J. F. Williams (Chairman, Sheffield Mental Welfare Committee): I think the first thing that strikes anyone after hearing Dr. Fildes is the need for some definition as to what is meant by the homeless child. Are homeless children only those who have lost parents and those homeless children who, by perhaps force of circumstance, have been removed by legal proceedings from the control of their parents? I suggest that the problem of the homeless child is not merely that want of a home, or that separation by legal proceedings, but that of really being homeless though the home be there. I live not very far away from three working class clubs and, as a working man, may I make an assertion which I know may not be upheld by all working class people. You can go into any industrial city throughout the country and you will see outside those Working Men's Clubs for adults young children waiting for their parents on the Saturday, Sunday and Monday, Tuesday the dogs, Wednesday the Speedway; and the result is they are as homeless as if they had no home at all. That has to be faced. It is a job of work we can all do, to discourage what might be wrong and what might injure the children. As far as the care of these children is concerned, I am convinced that the only way of caring for the homeless child, once away from its parents, is the foster home. See to it that the character of the foster parents is good and that the children are brought up as ordinary children, prepared to face life as they ought to face it.

Dr. R. E. Lucas (Physician, Tavistock Clinic, London): Even after twenty years' close contact with her it is always the greatest pleasure to me to hear Miss Fildes. There can be few people in this country, I think, who have served the cause of childhood with greater sincerity, conscientiousness and wisdom.

There are just three points I want to bring up. In the first place I do not think we are making sufficient use of the foster-home system. During the war the situation with regard to placement of children in evacuation areas was somewhat discouraging and I think the idea has developed that foster-home placement is very difficult to achieve. Nevertheless, a month or so ago when there was a newspaper report of a delinquent boy who was seen in Court and was found not to be wanted by his parents, people from all over the country wrote to the newspaper offering this delinquent boy a home. I wonder if we are using the right methods or whether we could not, by means of newspaper publicity, accumulate a large register of really suitable foster-homes for children?

My second point is that the first means of helping children in institutions is by adequate selection of staff. Yesterday we heard how valuable personnel selection methods have been in the army. I do not think it is beyond the wit of these specialists in personnel selection to devise methods which would enable us to assess the personality of people suitable to undertake the care of children. We want to discover not fanatics who "adore children", but normal, ordinary people who can enjoy children and take them in their stride. I think this would be one of the most important means of obtaining for children what Miss Fildes has so admirably described—that feeling of belonging to someone.

My third point concerns the temporarily homeless child in hospital. I have recently seen an illegitimate boy of six whose devoted mother has been a continuously sick woman. In six years this child has lived in twenty-two places—one foster-home, about fourteen hospitals, several convalescent homes and one or two institutions. Although fairly fit physically and of average intelligence on performance tests, this child cannot yet talk. I am not going to criticise hospitals as a whole, but I do feel inclined to say that in some Children's Hospitals there is a great lack of understanding of children's needs. (I have seen a boy of seven held down on a marble slab and given a lumbar puncture without any preparation or anaesthetic. Because the child was a general paralytic he was thought not to feel anything, but was, in fact, in a state of absolute terror.) I think it is time that we had greater co-operation with the physicians and nurses of general, and particularly of children's hospitals, since there is a large group of temporarily homeless children in hospital who do not receive the understanding they urgently require.

Mrs. Dorothy Archibald (London County Council Education Committee): We members of Local Authorities have a big responsibility in the matter of mental health, a responsibility which in the past we have not fulfilled and have only

recently realised. Our responsibility will be increased owing to the new Health Act and the new Education Act. Moreover we are aware of a great national need. That need was referred to yesterday by Mrs. Jacobin when she voiced the opinion held by many women, that the normal life of the normal married woman in this country produces in effect a great amount of neurosis. Dr. Bowlby has promised some developments in relation to this problem, and Dr. Main has given us an encouraging account of the work that can be done if we are to obtain full productive capacity in this nation for the emotionally and intellectually handicapped.

I want to address myself in particular to my fellow representatives of Local Authorities. My view is that the Child Guidance service for this country should be a focal point and that it should be considerably extended. The Curtis Report shows that while, with a few exceptions, we care physically for children, it is on the sociological and psychological aspect that they are deprived and the emphasis is on our failure there. Dr. Main referred to the effect on children of the changing habits of our population. We no longer have a static population, nor a fixed community in which children can grow up in security. We have a mobile population, which because of the needs of industry will become increasingly so. In addition we have the misery of the breaking up of family life caused by the last war. If we establish a thorough Child Guidance Service, making it within the reach of every child, we shall have gone far towards solving the problem of the child deprived of a home. In this way we shall be able to give our children an expert health service and by so doing ensure the mental health of this rising generation and the prevention of mental illness in later life.

Councillor Mrs. A. Ross, J.P., M.A. (Chairman, Edinburgh Education Committee): First of all, I want to say how gratified I was to hear the very human approach to this problem of the homeless child that was made by Dr. Fildes, and I thought it might help this conference if I explained what is being done by the Edinburgh Authorities.

We regard the institution as a second best method of bringing up a homeless child and the home as being the better method. Through our Social Services Officer we go to a great deal of trouble to find suitable homes for homeless children and the children are placed with very great care with families in all parts of Scotland. In all those districts we try to meet the religious needs of the child. The Roman Catholic child is placed with a Roman Catholic family and the Protestant

child is placed with a Protestant family. The child, boy or girl, attends the ordinary day school of the district and lives, as far as possible, the normal life of the children of the area. I am thinking, of course, in the main of normal children who, for various reasons, are homeless; but we have even been able to place slightly mentally defective children in such homes where they have had in some cases the most marvellous care from the foster father and mother. I look upon this problem as a mother as well as an educationalist. The normal life of the child is the home life and not that of an institution, however good it may be. I do not deny that in some cases an institution is necessary for medical or other reasons, but I do think our Edinburgh method of placing these children as far as possible in carefully selected foster homes is best for the homeless child.

Dr. W. J. T. Kimber (Medical Director, Hertfordshire Psychiatric and Child Guidance Service): The conditions which Dr. Fildes so ably described this morning we all know do exist, but it is an undoubted fact that in many parts of the country there are well-intentioned, well-meaning people who feel that these conditions do not apply to their own particular area. Not only well-intentioned, well-meaning people express this opinion, but people in authority for dealing with these problems, and I have difficulty in making these realise the conditions which have been described by both Dr. Fildes and other speakers, and making them feel that something should be done about it. I am a psychiatrist. Dr. Fildes is a psychologist. We are under a certain amount of suspicion by the ordinary well-intentioned person. What is the answer? I think it was given at the first session yesterday, namely, that the establishment of local associations for Mental Health related to and linked up with the National Association, can by their influence, support and guidance help those of us who are struggling in the provinces for improvements, to accomplish some of these very necessary reforms that have been advocated this morning. I hope that many of you here to-day will go away determined to do what you can to start local associations in your own area linked up with this newly formed National Association for Mental Health.

Dr. C. Davies-Jones (Director, Isle of Wight Child Guidance Department), in the course of his remarks urged that our attitude towards Child Guidance and provision for the homeless child should be one of understanding, and that our approach to the problem of the illegitimate child should be tempered with more Christian feeling and kindness.

Miss M. Hamilton (Regional Representative, Region 2, National Association for Mental Health): There are two points in Miss Fildes' address to which I would like to refer and which I think are of great importance. One was her reference to the present tendency of "looking to another Local Authority." I work in a big county which prides itself on its independence, and yet one finds that tendency operating there too; even worse, because not only is there the "looking to another Local Authority" before anything appears in the way of action, but the looking even further back, to Whitehall or some Central Department, for a directive. The plea I want to make is that, in so far as we call, or regard ourselves as, the children's Community Mother and Father, where you have in your local areas the problem of difficult or neglected children, you should acquaint yourselves with the problem and try to discover if there is some improvisation you can make to meet that group's immediate needs.

The other point is really subsidiary to that. How many of you here know what, for instance, your Public Assistance Home group of children is like? I was visiting one Home in my area not long ago in the company of the headmistress of a local Infants School, and she had hitherto been quite unaware of that little group in the centre of the town. It happened to be a particularly barren and miserable little group. I wonder how many people in that particular County Borough knew what that group was going through?

I would therefore ask: Will you not go home and find out about the neglected orphans and the deprived children in your area—perhaps in your own street?

Juvenile Delinquency

Margery Fry, M.A., J.P.

I have heard so many things this morning with which I profoundly agree and so few with which I have any quarrel that I feel almost ashamed to stand up before you. The subject we are dealing with is largely a question of definition. It is constantly forgotten that definitions are apt to be good only for the exact quality used in making them. If you get a really scientific definition of a particular animal, that is to say if you have got hold of the specific qualities, other qualities will follow. If you find a small animal with a tabby fur and pointed ears and a good tail, you will be sure it will say "meouw" and like milk—because

scientific specifications have been worked out so that they coincided with the differences in the creatures who have been classified. But this is not true of much of the ways in which we classify our fellow human creatures. We classify them into German and Frenchman and Chinese and English and believe that these names carry with them a whole lot of implications. Sometimes they do, more often they don't. This classification on which I have been asked to speak to you this morning, in talking of the care of the delinquent child, is not one which carries with it all the other qualities concerned. It is a very rough and unsatisfactory classification of children. For one thing, whether a child comes before the Court accused of an offence or of being in need of care or protection or whether as a truant or as being beyond control, is often a mere toss up.

The group of children which I have been asked to talk about to-day are just those who, accused of breaking the law, have been brought to court. They are a peculiarly important class of children because our treatment of them is really a first line of defence against the adult criminal. Many people think children's courts are hardly to be taken seriously; on the other hand, it is the adult court that has less chance of stopping crime. The juvenile courts have such a chance. These maladjusted children are one of the most important concerns of the community, because the earlier you can deal with that maladjustment, the greater are your chances of putting it right; much maladjustment is discovered almost too late. I have been glad to hear previous speakers stress the importance of treatment in early childhood. I often think of this matter in terms of gardening, and dealing with such delicate plants as wisteria. All those who have tried to grow this know that if you touch its tendrils roughly the whole spray dies, on the other hand, the direction that the tendril takes towards the sunshine it needs is important for the growth of the plant. I think much the same is true of the incredibly delicate tendrils of the social development of the baby. How many of you know Dr. Merrell Middlemore's book on the nursing mother with its most minute study of the beginning of the social sense between the child and its mother? I do not say that if the social sense is injured in those early days it may not be possible to make good afterwards. But it is very important that the development of those social instincts (which are normal to the human being who is a gregarious creature) should not be injured in early childhood. The work of Dr. John Bowlby shows that if they are injured we run a great risk of forming delinquents. I remember a boy of 12 or 13; perfectly well-behaved as long as

he remained with his foster mother, who was snatched away from her to be put into an approved school. The whole of his life had been upset. With a great deal of trouble he was returned to his foster mother, the one person he wanted and who filled a great need in his life. But by then he was so difficult that eventually she had reluctantly to admit that she could not have him. It was too late and she had to give him up and the boy was charged again.

I have noticed the same thing of children returned from evacuation who have come back to unsympathetic homes. It is clear that these breaches of continuity are of great importance in the production of delinquent children and should be avoided by every means.

I cannot see why babies should be lumped together. Why, if we have cottage homes, cannot there be a baby in a cottage home? I am quite sure you cannot develop the social sense in connection with a whole lot of people. The natural thing for the very young child is to look to one person. If that cannot be the mother, you must find some other person who can give it the feeling of being its special protector.

When we come to the question of the care of children who come before the court I think the subject of classification is of enormous importance—in the first place, classification of cause of offence. You want to find out with the help of rather overworked psychiatrists and psychologists whether the child is heading for difficulty, or whether he or she has been up to some childish prank, which is perfectly normal. Don't let these latter children be taken from their homes either for foster or institutional care.

Then you must consider what is the right way of treating the child. The Home Office has started classification schools for children committed to approved schools. I have only visited one of them and I was greatly impressed by it. I thought it was doing excellent work under difficult material conditions and was not doing it in too much of a hurry. The boys were carefully observed from every angle. They were in small groups with a house-mother and a house-father living in a small temporary hut. The people there said, and I am sure they were right, that the classification was coming too late in one way because the decision had already been made to send the children to a school.

After what we have heard this morning, I think no one will deny that the first and most important question to be decided is this problem of whether a child is to go to a school or not. Personally I am, and have been for many years, tremendously in favour of boarding out when this can be

managed. I think we have not exhausted the number of good homes in the country. The evacuation scheme had the defects of haste. It was not altogether successful in every place but there was an enormous number of successful foster homes for the evacuated children, and I believe there was the discovery of a great deal of unused maternal instinct in the mothers of this country; unused sometimes, because their own children had grown up and because they had not had the initiative to adopt children on their own or had been unable to do so on financial grounds.

I feel that we are not yet using the Women's Institutes sufficiently in this matter, and that these could still help even more in finding foster mothers. It would be a very good thing if the Women's Institute could feel generally responsible for the well-being of one of these children in a country village.

The London County Council has something like a scheme which was working marvellously well before the war in Rumania, and which was started by a woman who had been brought up in England in a convent school and had been miserable. She vowed that no child she had anything to do with should live in an institution, and so spent her money in boarding out children around a centre. They were looked after so that the whole responsibility was not laid on the foster mother. There were nurses and doctors in the centre to which they could come. There were cinemas for the whole population where they went with their foster-brothers and sisters. It is asking rather much of foster parents if they cannot have a little more support than can be given by the occasional visit of even the best inspector. I should like to see nurses and probation nurses available for the children, although I quite realise we must not let them feel themselves different from other children. I am afraid, however, that foster home treatment is not suitable for all delinquent children. There are some of them desperately difficult to deal with. Some of them need a special kind of skilled attention which no ordinary foster home could give them; they sometimes need special physical care, very often psychological treatment. Some of them do need the sort of rhythm of a school which carries them along so that it becomes normal and natural to behave decently, because many of those around them are also behaving decently. The approved schools in this country are a very mixed bag, but, on the whole, they have improved enormously since I first began to take an interest in them. I remember one school where boys stood on sentry duty the whole day to prevent others from running away. I remember another I visited on a day when the

dining room was bitterly cold for little boys in not very good clothes and, on my mentioning it, the matron remarked it would warm up when the children were in it. I thought that was a cruel idea and significant of a very bad attitude. But I have visited Home Office schools which seemed to me excellent of their kind and where I should have every confidence in placing children if the more normal treatment of the foster home was impossible.

There is one point I should like to raise for discussion on this matter. Is it common sense that we should cut off these Home Office children, as I am going to call them, from the rest of the maladjusted, difficult and homeless children of the country? Is there really any great distinction between the child who has gone through the courts and the child who has not? Is it not absurd to go on maintaining 8 years as the age of criminal responsibility? I saw one case described yesterday where it was said a boy of 7 and one of 5 were charged with burglary. It must have meant that they had been brought before the court as needing control; but they got a newspaper paragraph! It is doubtful whether it is legal to hold a child under 13 criminally responsible without proving that he is capable of knowing what is right and wrong. I hope we shall follow the example of many countries and make a conviction impossible under the age of 13 to 14. They are not called convictions now but findings of guilt, but it is bad for a child's future if everyone knows he has been found "guilty" of some criminal offence at a very early age.

In the meantime I think we must try to back up the Juvenile Court by voluntary associations outside, by child guidance clinics and educational facilities for the difficult child, or delinquent child. It is important that children needing care should be sent to hospitals for treatment for mental or physical troubles, and that if possible the same committee should advise on both. We must, however, have the legal tribunal as a court of appeal for parents who maintain that their child is not in need of any special treatment arranged for by the community. You must not undermine parental responsibility by denying parents a chance of being heard in open court, and of showing cause why their children should not be taken from them or treated for them. With regard to children themselves, we are to rely more and more on child guidance committees, and later on it may well be that only the disputed cases will come into children's courts. The question of guilt or innocence is so very far wide of the mark. The important thing is what has gone wrong with the child and what can be done to help it. There is a practical reason for not immediately introducing a change in this

matter. Obviously the new Education Act is going to lay a tremendous burden of responsibility on all local authorities in providing treatment for special classes of children. The Ministry of Education admit that about six and a half times as many deficient or dull children need special instruction as are getting it. I believe when the community's duties in that matter are fulfilled by the local authority as they have to be under the new Act, we shall discover a large number of children of sub-normal intelligence. Work recently done by the Bristol Child Guidance clinics in connection with the Children's Court has proved this. When accommodation is provided for maladjusted children (for the first time under the new Education Act recognised as a special type), a number of them will never come to the courts.

Why do I not suggest that the children's courts should at once abdicate and the children coming to the courts be placed under the Ministry of Education? Personally I am in no hurry to see this change made. Under the new Act the Ministry of Education and the education authorities have an enormous task set before them. Meanwhile it is important that the Approved Schools should continue their work, and if enough classifying centres can be got going and kept in close touch with the schools (so that they are able to induce the schools to provide for varying types of children the right kind of education), we shall get an experience which will not be wasted when the numerous schools set up under the Education Act begin to function.

I do not quite agree with what Dr. Fildes said when she advised that no local authority should see what others are doing. I think something might be gained by visiting the best schools and classification centres.

The delinquent child needs the same care as the difficult and the maladjusted child in the general population needs. I regard it as only an interim measure that those children should be set apart and classified as needing special treatment. In the meanwhile, it is the job of every member of the community to know what is being done for them and, where children have to be sent to a school, to prevent their getting separated from the general community, as is otherwise too likely to happen. I do not know if it is possible for any members of the audience sometimes to ask two or three children to come from a neighbouring school and have tea in a friendly way. That kind of contact with the general population would be doing something to break down that most dangerous of all barriers which makes the child think of himself as anti-social.

DISCUSSION

Dr. Denis Carroll (Director, Institute for the Scientific Treatment of Delinquency) agreed with Miss Fry that there was little difference from this point of view between mal-adjusted children, children beyond control and delinquent children, or even so-called "normal" children. Given certain innate factors it was largely a matter of accident whether the kind of environmental factor which could then upset matters occurred at a dangerous moment or not. Prevention depended largely on ensuring a suitable physical and emotional environment, especially in early life.

Once a problem had arisen there were bigger differences, e.g., it was often necessary to tolerate bad behaviour in a child for a while if cure is to be achieved. The less delinquent and the younger a child is, the more practicable it is to extend this toleration to it. This is very true of children who become worse when punished. So both prevention and cure are likely to be more effective and practicable if begun at an early age, and we should not wait for delinquency to appear but begin at the first serious sign of maladjustment.

Some consider psychiatric advice should always be sought, but numbers make it impracticable and it is not really necessary. For delinquents, the criteria for routine psychiatric examination should be (1) obvious maladjustment when first charged, (2) recidivism, e.g., at the second or third offence. The powers of the Juvenile Court were a real help and people were getting less frightened of calling on them. The main thing was to do something at the first sign on general common sense lines and to go to the Court and to the psychiatrist if this did not work. The more we educate parents and teachers the more correct will this common sense handling become. If the problem is serious or persistent then full investigation is essential. One cannot hope to cure and prevent delinquency without knowing its cause and only full investigation can tell us this. There has been a much greater realisation of this in Courts of late.

Classification before choosing a school or home is important but let it be done before sentence, not after. Sentence should be given in the light of the knowledge obtained at classification centres and one need not go to a classification centre to get that knowledge. Child Guidance Clinics were springing up everywhere and could provide it.

Psychiatric data of this kind should be put before the Court as evidence as to character, and not as a plea for the defence or prosecution. The psychiatrist's proper rôle is to assist the Court to arrive at a true assessment of causes

and likely reformative measures. Probation Officers can and do get much of the data required and are much better trained nowadays.

Dr. Carroll said that there was a woeful lack of provision for the child who needs psychiatric medical aid away from his own home. Money was the difficulty and more should be paid to foster parents so that the right kind of people could afford to act as such. It was not a question of can we afford to spend the money directly on such medical measures, but rather can we go on spending it indirectly by allowing juvenile delinquency to occur unnecessarily as we do at present. Juvenile delinquency was not out of hand, and seemed to have passed its peak. In assessing results we had to remember the high proportion of spontaneous recoveries. We needed also to remember that our aim should be to produce well-adjusted and not merely non-delinquent citizens.

Finally, it should be remembered in discussing the need for caring for children away from home, that separation from its home is a serious matter for the child and may be more harmful than a bad home. Thus our aim should be to improve the home where practicable and to look on 'taking away' as a second best.

Dr. Leslie Housden, O.B.E. (National Association of Maternity and Child Welfare Centres): I wish to speak on something we practically never hear of in conferences such as this, namely, the prevention of delinquency. We are much occupied in considering its reform, but do little about its prevention. If we trace back the history of any delinquent, we shall find a point where he or she is not a delinquent. No baby is a delinquent in its cradle. There will always be a time when delinquent tendencies are first shown, and at that time the people with whom the child is most in contact are the parents. It is because the standard of parentcraft in this country is so low that the rate of delinquency is so high.

We hear a lot about broken homes, but the last group of boys I went to see at an approved school were mostly from homes where the father and mother lived together, and three-quarters of them were said to be happy ones. That may or may not have been the case. A broken home does not necessarily mean that the parents are living apart.

What do we mean when we speak of delinquency? If we mean stealing, it seems to me ridiculous for us not to expect our children to steal out of Woolworths when they have just drunk their tea out of cups with the initials of the local railway company on them. If we mean sex immoral-

ity, parents once more bear a grave responsibility. We hear a lot about irresistible sexual urges and things like that. What nonsense this is, to be sure! I do not deny the existence of such an urge. I have a strong urge towards vintage port, but because of my family I occupy myself in other ways.

Every child must feel wanted; the feeling of belonging to someone is so important. We talk a lot about security, but the feeling of security in any child is the wonderful feeling that others could not do without him. In many homes the children feel unwanted, and if an adolescent girl feels unwanted, she is likely to go out and find someone who does want her, if only for an hour.

Another important problem we must face is the sense of boredom felt by so many children in a world so full of interest.

Mr. A. Royds (Director of Education, Rochdale): I contend that there is a sufficient number of Mental Deficiency Act Committees in this country which are contributing to the amount of juvenile delinquency. My own experience is of a Local Education Authority which has taken a good deal of pains about the subject of juvenile delinquency, and as a result I feel that the more effectively that Education Authority does its job in determining those children who are so chronically mentally ill that they have to be described as "ineducable"—a most unfortunate word—the more does it create a body of potential delinquents. Once those children have been classed ineducable, the Education Authority cannot continue to deal with them; it must report them to the appropriate Mental Deficiency Act Committee. That Committee appears to be quite powerless to deal with them. I know the number of ineducables is very small, but the smallness of the number quantitatively is not at all commensurate with the importance of the problem qualitatively.

Dr. J. de Ville Mather (West Riding of Yorkshire Mental Deficiency Committee): I am Medical Officer to an approved school and I have 75 boys under my care from a medical point of view. If they are happy they keep well, and if they are miserable they go sick and they abscond. I have two suggestions I would like to put forward. Firstly, give us some books to read, something that the boys can take an interest in. My experience is that they are greedy for books.

Secondly, let them have a taste of music and if you can give them some other musical instrument than the horrible cracked piano I seem to see in all these places, they would be grateful.

My last point is this, and I am treading on tender ground. Why is it necessary to dress them in slops with soles on their boots two inches thick? Let them dress as citizens and go down to the local Municipal Library; let them live as other children—and I should not find I have 25 per cent. nail-biters, which is a symptom of the nervous instability from which they have suffered.

Mrs. Nora Heron: I am speaking as a mother and a lover of children. I have been very interested in the points of view put forward, and feel very strongly that many of Miss Fry's problems with delinquent children would never arise if the conditions to which Miss Fildes has drawn attention in regard to the homeless child were given first claim. As a Social Science student during the war, I had occasion to visit many institutions, and from my own observations I wish to make the point that the execution of their good ideas so often falls short of their intention.

I would therefore ask members of Local Authorities here to-day if they and their Committees dealing with children in any way would make themselves conversant with every aspect of a child's needs. I have had a little experience myself as a Councillor and have been astonished at the number of people sitting on Maternity and Education Committees who know very little about the needs of children and the progress which is being made in meeting these needs. I beg of you to take every possible means of making yourselves fully aware of what is happening in your own areas, and to see that the spirit as well as the letter of the law is being carried out in dealing with children.

Mr. Sidney Harrison (Probation Officer, Stoke-on-Trent): As a probation officer engaged in the field work of delinquency, I would like to bring before your notice one aspect of it which I feel is of considerable importance to this Conference. It is the question of the connection between mental subnormality (not necessarily certifiable) and delinquency. I find in the majority of my cases that although there is the emotional problem of the broken home, there is also the problem of the person who is just sufficiently below the average mentality for life in general to be a constant fight which he can never win in the face of the competition of more normal people. It is not surprising, therefore, that he sometimes takes a path which leads him into the hands of the law.

Dr. Lucy G. Fildes: I want to refer to one point which was made by Dr. Denis Carroll. He commented broadly that

magistrates were now willing to learn. I think there is a dangerous tendency that, having changed from the view that the psychiatrist is a mischievous, interfering individual, hindering the process of the law, magistrates now tend to regard the psychiatrist as an omnipotent being who has only to be called in for the whole situation to resolve itself.

I would like also to call your attention to the crying need for short-term observation departments for children—I mean residential care under normal conditions for a short term. This need is not altogether fulfilled by remand homes, and the result is very unsatisfactory. I think in cases like this, where decisive action is necessary concerning a delinquent child, or one not necessarily delinquent, a difficulty may be that there is an inevitable delay because it is felt that the decision taken is not going to be easily alterable. On the other hand, it may occur that a psychiatrist is forced into the position of making a decision too soon before he has had an opportunity of observing the child under something approaching normal conditions. It should be possible for many local authorities to provide some sort of hostel, something different from remand homes for these children.

END OF MORNING SESSION

FRIDAY, NOVEMBER 15th
AFTERNOON SESSION

Chairman:

The Rt. Hon. R. A. Butler, M.P.

The Chairman: I feel much honoured to be asked to take the chair this afternoon and, as I have so much to learn from what we are going to hear, you may be quite sure that I shall not detain you very long. When I accepted the invitation I told the organisers that I have another engagement in the country to-night, unfortunately, so that after these papers are contributed Lord Feversham will take the chair for the discussion on the papers, so you need have no sense of despair when you see the change of chairman in the meeting.

Before calling on Dr. John Bowlby, I should like to say what personal pleasure I have in being here this afternoon. I am in the unfortunate position of having put through what is regarded as a major social reform in the Education Act and then being temporarily out of work and having to watch the development of this measure, I suppose, for the rest of my life. As I am at the present moment in excellent psychological and medical hands, it seems to me I shall have a long life, in which case I am going to have to face many troubles—but, nevertheless, whether I face troubles or not, I think the work of the Education Act, and the particular aspects of it which may be discussed to-day, are of supreme importance to the future of the nation. We did decide—those of us who took part in this measure of all parties of opinion of every type in the country—that there was an important aspect of children's future happiness and of the Education system which should not be omitted from the Act. I should like to take this opportunity of saying that much of the credit for the sections of the Act which deal with the matter we shall discuss this afternoon, is due, not to Ministers of the Crown, but to a man who still remains in the Ministry, my principal adviser at that time, Mr. Nigel Bosworth Smith. I mention his name, because it is usual for Ministers to get all the credit and, in this matter, I can assure you that the main credit for that portion of the Act goes to him and to his helpers and to my advisers. These questions were definitely technical and important and such as you would not expect a Minister to be a real expert upon, however clever he might think he was. I have derived great value from my association with those advisers who helped me and I feel quite certain that

the Act, in so far as it is good, is due to many other people whose names are not publicly broadcast or mentioned on platforms.

The subject we are to consider this afternoon is the various bringing together of the psychological services, which under the Act are of supreme importance and matters in which I take a great personal interest. To maintain my reputation as Chairman I will now give way to Dr. John Bowlby whom I have great pleasure in introducing to you.

The Future Role of the Guild Guidance Clinic in Education and other Services

Dr. John Bowlby, M.D.

(Psychiatrist in charge, Child Guidance Unit, The Tavistock Clinic, London)

Child Guidance was originally conceived as a preventive service. The Psychiatrist had recognised that most forms of emotional disturbance and mental illness had their roots in childhood. The Educational Psychologist pointed to the value of the early recognition of children of different abilities so that they could be given appropriate education from the start. The Social Worker was aware of the domestic and social catastrophes which developed if children were neglected and left in bad home surroundings. Yet, though conceived as a preventive service, we find that in fact it is at present nothing of the kind. The Clinics to-day are flooded with children already in serious difficulties. There are children whose schoolwork is many years behind their mental age, children suffering from severe phobias, children who have been truanting for months or years, children who have become unmanageable and destructive, persistent delinquents and children who have become chronically too good. It is true that sometimes we find the problem is not severe and that relatively simple means will suffice to put matters right. All too often, however, the trouble has been progressing for many years and the Clinic is being used as a last resort. For instance, an overwhelming majority of cases referred by certain great Local Authorities is of this kind. Only when the case has become hopeless is Child Guidance tried. The same is true of most Court referrals. Only when the condition is patently of emotional origin—such as a telegraph boy whom I saw recently who had collected unopened in his bedroom 400 telegrams he had been given to deliver—only then are cases referred to us; and by then the trouble is often far too advanced for any but prolonged

and skilled treatment to be of any avail, and this, as we all know, is hard to get and inevitably expensive. Because of this it is clear that, whatever the future rôle of the Child Guidance Clinic is to be, the present rôle is extremely unsatisfactory and requires radical change.

The Child Guidance Clinic must continue, of course, so long as disturbed and sick children are with us, to provide treatment and other forms of help for them. But the Clinic must become a part, and perhaps only a small part, of a Child Guidance Service designed to promote mental health and emotional adjustment, and to detect at a very early phase children whose development is going wrong. The tuberculosis services have shown us the way. Instead of waiting for children to develop lung cavities, collapsed vertebrae or disorganised hip joints, as was the case at the turn of the century, they have insisted on the importance, first, of good food and sunlight and, secondly, of almost routine X-ray and drastic action at the first signs of trouble.

This preventive programme, involving a tremendous expansion in trained professional personnel, both medical and non-medical, was achieved in the course of a generation. It is our opportunity, thanks largely to the Education Act of 1944, to achieve something similar in the prevention of emotional disorders.

Let us consider what a preventive service would entail, how it would fit into the present administrative arrangements, and who would be responsible for running it. Then we can return to consider the place of the Clinic as part of the broader whole.

Dr. C. P. Blacker in his valuable survey of the Mental Health Service has advocated a sort of Pakistan—the setting up on the one hand of Child Guidance Centres presided over by Educational Psychologists, and run by the Education Authorities, and, on the other, of Child Guidance Clinics given over to the treatment of ill children, directed by Child Psychiatrists, and under the auspices of the Health Authority. Such a proposal seems to many very ill-judged. So far from integrating the work of medical and educational psychologists it would set each up in his own little kingdom. Preventive and curative work would be divorced from each other to the disadvantage of both. Research would be hampered and facilities for teaching impeded. Above all, there would be the inevitable friction, delay and divided loyalties due to the members of what should be one team being ultimately responsible to different Ministries in Whitehall.

An alternative proposal, though one which only deals with part of the problem, has been advanced by the Association of

Education Committees. In their report on the subject published earlier this year they advocate the setting up of a single service under the direction of an Educational Psychologist, and under the Education Authority. This would provide a unified service, it is true, but the functions of the medical and educational psychologists are rigidly separated, and it is made plain that the medical remains chained behind the iron bars of the Clinic, and is permitted to play no part in the work of prevention, early diagnosis and early treatment. I need hardly say this proposal does not commend itself very warmly to child psychiatrists, or for that matter to Child Guidance workers who have had the experience of working in a team of Psychiatric Social Worker, Psychologist and Psychiatrist. To many of us it appears to be one more shot in the old feud between medical and non-medical Psychologists which has done so much to retard progress. So far as I know, since Dr. Blacker published his report, no psychiatrist has had the temerity to advance the opposite view—that the whole Child Guidance Service should always be directed by a psychiatrist, though this has frequently been argued in the past (I recall with shame an occasion when I did so myself). Only the Psychiatric Social Worker, it appears, is modest enough to make no claims to being top dog. Perhaps that is because she is so often the most experienced member of the team, and is so often the one who is really responsible for the organisation and work of the Clinic.

Who, then, should be responsible for the organisation of a Child Guidance Service, and what part should different members of the Child Guidance team play? Perhaps if we get away from professional jealousies and consider the work to be undertaken we shall get a clearer view.

In the forefront we must put the planning of services designed to prevent the onset of psychological problems in children. In passing, it is interesting to note that neither the Education Act nor the Ministry's pamphlet on special educational treatment touches specifically on prevention. The same omission is to be observed in the report of the Association of Education Committees. Yet it is clear that prevention must be the first consideration of a Child Guidance Service. In planning our programme it is a comfort to find such a large measure of agreement as to where we should begin. Almost everyone who has studied the problem of personality development, from the Jesuit to the Psycho-Analyst, has recognised the cardinal importance of the early years of life. A person's capacity to make good personal relationships and to tolerate frustration and difficulty without losing heart is known now to be, to a high degree, a function of his relationships with his brothers and sisters, his father and above all his mother in his first five years. In this

matter the experience of scientists has merely confirmed traditional knowledge, though in doing so I believe it has greatly extended our understanding of the problem. One of our first tasks, therefore, must be to help in the promotion of satisfactory family relationships, especially mother-child relationships. It would take far too long to recount all the useful measures which should be taken, but it is clear that work in the Maternity and Child Welfare Clinics, in the Nursery Schools, Parent-Teacher Associations and community centres will be of special importance. Already psychiatrists are holding discussion groups for expectant mothers, and in several Maternity and Child Welfare services child guidance is an established feature. Such developments are of the greatest significance.

Another aspect of preventive work which we shall hope to see developed in the next few years are services for children deprived of a normal home life. There can be little doubt that the loss of parents and home, especially if it occurs in the child's early years, can have far-reaching adverse consequences for character development. At the worst, the victims may grow up incapable of feelings of affection and motivated only by sullen revenge, but for everyone so damaged there are probably dozens whose capacity for happiness and good social relations is impaired. The publication of the Curtis Report, we hope, will open a new era in the community's care for these unhappy children. In a memorable paragraph (327) this great State document lays it down that, if the child is to get what he needs, a substitute home must supply :

- “(i) Affection and personal interest; understanding of his defects; care for his future; respect for his personality and regard for his self esteem.
- (ii) Stability; the feeling that he can expect to remain with those who will continue to care for him till he goes out into the world on his own feet.”

It is no accident that on the committee responsible for this report sat two distinguished child guiders and it is evident that, if it is to be implemented, personnel with Child Guidance training and experience will be required on a great scale. Already some of the larger voluntary societies caring for these children are employing Child Guidance teams, and it is to be hoped that Local Authorities will not lag behind.

Another great field as yet little explored is the design of schools as social communities in which even adjusted children may develop more favourably, and those with some degree of maladjustment will improve. They would thus be planned for both preventive and therapeutic work. Much experience has already been obtained in various pioneer schools and com-

munities, in hostels for maladjusted children and elsewhere. Certain principles seem to be emerging, but if this work is to develop quickly and effectively workers trained and experienced in the emotional development of children will be required.

Another great field in which the personnel of a Child Guidance service will be called upon to play a large part is the education of parents, teachers, and, perhaps most important of all in the next few years, that immensely responsible and influential body of women, the health visitors. It will be a campaign for psychological health comparable to the campaign for fresh air, sunlight, good food and cleanliness carried on last century, and which has had such great results in promoting physical health. Some may wonder what principles of psychological care should be taught. I shall not enter this controversial field this afternoon, but the question serves to remind us how ignorant we are of many aspects of our problem. The only cure for this is research—systematic team research into the origins of maladjustment. That is yet another task for the service we wish to build.

These then are some of the requirements on the side of prevention which our service must meet.

Next in priority comes early diagnosis, but that is a problem bristling with difficulties and requires a paper to itself. One thing should be evident, however—that those with most experience of diagnosis must have access to all children and must no longer be dependent on a selection carried out by well-meaning laymen and medicals untrained in even the rudiments of child psychiatry.

Finally comes the therapeutic side of the service, for which the Clinic is designed. To it will be referred cases where regular treatment is indicated, and also cases where the diagnosis is difficult. Much effective treatment will, of course, proceed in school and hostel and foster-home, but there are many cases for which regular psychotherapy is essential. Within the walls of the Clinic, therefore, will proceed, as at present, child therapy, remedial teaching, and the psychotherapy of parents which often proceeds so effectively under the disguise of “intensive social work”. The Clinic or Centre, whichever word we prefer, and they must not be separated, will moreover be the base from which the Child Guidance team will operate, and will be the focus of teaching and research. In it, let us hope, psychologist and social worker, psychiatrist, teacher, school medical officer, probation officer and all who have to deal with children will meet and get to learn of each other’s work.

Having surveyed the task to be done we can perhaps see more clearly the administrative arrangements which will be

required to achieve it. In the first place it will be obvious that it is only by mobilising all the professional skills available that we shall be successful. We shall need personnel who have made an intensive study of the causes of emotional maladjustment; personnel experienced in the care and foibles of small children, people who understand the difficulties both emotional and material of being a mother or father and can use that understanding to help them, people who have a grasp both of the psychodynamics of emotional maladjustment and of the intricacies of test construction and who can design for us diagnostic tests, and people skilled in the clinical and physical examination of the child. We shall require people trained in teaching and experienced in education generally, people expert in the appreciation of the total situation as presented by test results and psychological, physical and social investigation and who can recommend treatment, people who have specialised in designing therapeutic communities and people skilled in individual and group therapy. All these people will be wanted. It is evident that some of these tasks can only be carried out by a doctor, others only by an educationalist and others again only by a social worker. But many of these skills are the prerogative of no one profession. Some of the most distinguished child therapists are psychologists, some of the best known pioneers in the construction of personality tests are psychiatrists, some of the most reliable diagnosticians in my experience are psychiatric social workers. Conversely, one may be a psychiatrist, or psychologist or social worker and have only the sketchiest knowledge of any of these skills. In other words, in a new and developing field it is training and experience in the particular skill which counts and not the professional label. Psychologist, psychiatrist and social worker must all be available to participate in all aspects of the service. There must be no water-tight compartments and no closed doors.

Who, then, it might be asked, will be in charge, and should the service be under the education or the health authority, and, if under the health authority, should it be the local authority part or the regional hospital part? As was indicated when dealing with the Blacker report, it seems to many of us that the regional hospital part of the health service is not well adapted to this service. Apart from the administrative difficulties, only a minute fraction even of the psychologically ill children require hospital investigation or treatment, whilst, on the other hand, preventive work is clearly related to the Maternity and Child Welfare and School Medical Services, both of which come under the major Local Authorities. Although the Child Guidance Service clearly belongs to the Local Authority part of the Health Service there need of course be no divorce from the Mental

Hospitals. It should be easy and to the advantage of all concerned for psychiatrists to work, say, half time in the regional hospital service and half time in the Child Guidance Service of the local authority (though such half-timers would not be well placed to take responsibility for the whole Child Guidance Service itself).

Finally we come to the knotty problem as to whether the education or the health committees of the local authority should take responsibility for the service. Each has undeniable claims and in different parts of the country each has a good record of having organised efficient Child Guidance Services. It is useful to bear that in mind and to realise that neither the one party nor the other has any special rights in the matter. The one important thing is that Child Guidance should not become a bone of contention between two warring departments. (And from the bone's point of view it sometimes looks as though health and education departments regarded the other as its natural enemy.) Being in a very real sense the concern of both departments one may hope that whatever arrangement is come to, the Child Guidance Service will be able to draw strength from both.

No doubt, in our traditional British way, solutions will vary in different parts of the country. To many concerned with Child Guidance Services it seems of the greatest importance that it should be easy for either an education psychologist or a child psychiatrist to be put in charge, whichever is better suited. This seems to many of us to be the answer to the vexed question as to who should be boss. To insist that it is always a member of one profession or the other is foolish. In the first place, the number of workers fully equipped by experience and personal qualities to take responsibility for a service is few indeed in face of the demand. Those who are, are to be found amongst all three professions—psychologists, psychiatrists and psychiatric social workers. To rule out any one class in our present predicament would be folly. And let it be remembered in reaching the decision who it is to be in any one case that, of all the qualities to be looked for, the capacity to appreciate the value of the work of the other members of the team, to give them the best conditions for developing their skill and to get all to pull together in a happy party, that is the most important. For it is only by mobilising all the skill we can command and tackling all the aspects of the problem as a united team of Child Guidance workers that we shall emerge from this, the *primaeval* period of Child Guidance.

The Integration of the Psychological Services under the New Education Act, 1944

Norah Gibbs, M.A.

*(Educational Psychologist, National Association for
Mental Health)*

The titles of these two papers suggest that they are on related though different topics. Actually they are on the same subject: the extension and integration of various services, clinical, social and educational, which contribute to children's welfare.

Dr. Bowlby has surveyed the field, emphasising the need for a concerted attack on the causes of maladjustment. He has urged that psychiatric and psychological knowledge should be used intelligently to prevent maladjustment: that is, that it should be available outside the walls of clinics. And he has spoken strongly against stultifying rivalries, either departmental or professional.

I want to follow with some special pleading along certain of the lines that he has laid down.

The dovetailing and interlocking of services in an area is a necessary step towards integration. But dovetailing, however satisfactory, is not the whole story. Integration of any health or education services (and child welfare in its widest sense is both) lies, I think, in the acceptance and extension by all the agencies concerned of certain basic principles of child care and child development. This includes:

- (a) Appreciation of the bond between mother and child and of later family relationships.
- (b) The essential continuity of individual development.
- (c) The emotional and intellectual needs of growing children.
- (d) Individual differences between children.

The need for such integration may be illustrated by reference to specific services and their relation to one another.

One cannot consider in detail the symptoms and histories of any collection of maladjusted children, or even of one maladjusted child, without being forced to consider causes. To say that all maladjustment is due to environmental factors only, is, of course, to over simplify. But there seems little doubt that environment has adversely affected many of the children who are presented at Child Guidance Clinics, or who are

recognised as maladjusted by those who have to deal with them. And, as Dr. Bowlby has suggested, good handling during early childhood matters, or, put the other way, unsuitable handling in the early years seems a recurrent cause of later behaviour and personality difficulties. Now it is often claimed that parent education would go far towards the prevention of wrong handling, but parent education is not yet universally available, and, if it were, not all parents would avail themselves of it. In any case, there is always the baby who won't conform to the rules! What most parents look for, I think, is sound advice *when* they need it, that is when they come up against a practical difficulty. And they want it to hand *where* they commonly seek advice—that is, in Maternity and Child Welfare Clinics, or from Health Visitors in their own homes. A separate psychological service for young children would not only be impractical, it would also be disastrous because it would suggest that the “psychology of the young child” is something that can be separated from care for his bodily welfare. But neither can his bodily welfare be regarded as something detachable from his emotional development. A sound knowledge and understanding of family relationships should be an integral part of the training of all whose work includes the advising of parents, particularly advising mothers of young children. And an integral part does not mean the addition of still another subject “Psychology” to the training syllabus of Health Visitors, etc.; it means teaching based on the view that the physiological and psychological aspects of children's early development are inseparable. Health Visitors and Maternity and Child Welfare Officers are very influential persons and deservedly so. They have won a place of trust for themselves and are relied upon in times of stress and strain as friends and counsellors, and what they say goes. In day to day feeding and training difficulties, young mothers often need the support of someone whose practical advice relieves their anxiety—but not at the expense of the children's later development. Excellent courses for Health Visitors are already set up in some areas; under other Local Authorities psychological advice is on tap in Maternity and Child Welfare Centres.

It seems odd to call a paper “The Integration of Psychological Services under the new Education Act” and then to spend a substantial proportion of the allotted time in discussing services which do not come under the jurisdiction of educational authorities at all. But the orientation of those who deal with children under two has a great deal to do with the long-term effectiveness of certain provisions of the new Education Act, because advice given to parents plays an important part in the prevention of maladjustment. Moreover, it is an example of integration in the sense that I am using the

term—the integration of services based not on administrative spheres of influence, but on the acceptance of common principles which makes the official fence between departments into a friendly garden wall!

Now to turn to certain of the provisions designed for children of school age. Assuming that Child Guidance facilities are or will be made available for seriously maladjusted children needing therapy, what other services can be regarded as psychological? I think the special educational treatment intended to meet the needs of the various categories of handicapped children is in some sense a psychological service.

Unless Educationally Subnormal Children, whether their backwardness is general or specific, are recognised and given special educational treatment reasonably early, they can, and many of them do, have another handicap added to their backwardness; they become also maladjusted, or at best, unadjusted to school life, and therefore unable to profit by educational opportunity. All investigators from Professor Burt onwards have pointed out that the backward child's backwardness, if he is left to flounder along, becomes a personality difficulty. From examination of some hundreds of educationally retarded children over nine years of age, I would agree that every one had an attitude towards school work or towards himself which would be mildly described if it were called unhelpful. Some are ashamed; some are just confused and discouraged; the mentally healthier are usually defiant; they will assure one either that they don't want to learn to read or that no one has ever been able to teach them!

The understanding of the needs of educationally subnormal children rests on an appreciation of individual differences, particularly differences in the rate of intellectual maturation. Although most Training Colleges make a valiant effort to give their students some insight into the problem of teaching backward children, preparation for work with such a distinctly special group should hardly be regarded as their function. Young teachers, as the McNair report pointed out, should have solid experience with normal children before those who feel drawn to this specialist work have some training for dealing with the educationally subnormal. Any such special training of teachers of all ages is rightly regarded as a psychological service both in the therapeutic and the preventive sense. Unless these children are appropriately handled—well, at best they fail to profit by their educational opportunities, and at worst they turn up at Child Guidance Clinics labelled maladjusted, and are the despair of a special service which was not intended to cope with them.

I have suggested that, in relation to educationally subnormal children, it is the differences, particularly the qualitative differences, between them and so-called "normal" children that need to be appreciated. Turning to certain other groups of handicapped children, those with serious physical disability of one kind or another, I want to say the opposite. The *differences* between blind and deaf children on the one hand, and children whose capacity for sensory perception is unimpaired on the other, are only too obvious; so are the physical differences between crippled children and children who can run about. What sometimes appears to be less obvious is what all physically handicapped children have in common, not only with one another but with all children. In other words, what is most striking about a blind child is all too frequently his blindness rather than his childishness; about a crippled child it is the uselessness of his legs or the stiffness of his arms rather than *impulse* to physical movement which is characteristic of all children. I should say here that I am not an expert in the care of physically handicapped children; I am sometimes called in to give advice to those who undertake the care and teaching of these children and my admiration of such workers is unbounded. But I know many of them will agree that greater opportunity to study the intellectual and emotional, especially emotional, development of unhandicapped children would lead in some cases to a more fruitful use of specialist techniques for teaching the handicapped. Specialist techniques are directed towards defeating the handicap, to "getting the child up to standard" often by a rather mechanical approach, which obscures the fact that it is the child himself, by his emotional attitude, who should be the most powerful enemy of his own disability. It may be just coincidence, but I have been asked on three separate occasions in the last three weeks whether it is a good thing to blindfold a partially-sighted child in order to persuade him to learn Braille by touch. Obviously the questioners had a good, honest doubt in their minds—and they were as right as the partially-sighted children who were mentally healthy enough to reject blindness as hard as they could. This, of course, is a particular example but it raises a general principle: that handicapped children are sometimes difficult because they are emotionally normal. A partially-sighted child who refuses to behave as if he were blind, even to the extent of refusing to use touch instead of sight, may be showing signs of quite rude mental health, especially if he is young, although he is certainly a problem to his teachers, who may realise that he will later be blind. Again, when an adolescent cripple becomes unexpectedly tough or moody just before leaving a residential school for the outside world, the psychology of normal children gives a possible clue to the best

way to help him. The most comely girl and the most lusty or intelligent boy, in similar circumstances, may have doubts about the kind of figure they are going to cut in the world; for the sensitive but handicapped child this doubt is immeasurably greater.

The care and teaching of physically handicapped children calls for a very special kind of wisdom and self-discipline. Wisdom to realise and respect the normal emotional striving which is producing the awkward behaviour; self discipline to prevent an over-valuation of the more *convenient* behaviour patterns. Handicapped children who are patient, who don't try to climb out of windows, who never mention their disabilities, are easier to manage and to praise than the more adventurous or sensitive. But they may be sadly impoverished personalities. The backwardness of one group of nine-year-old crippled boys who could not read struck one psychologist as less abnormal than their unnaturally clean hands!

The application of psychological services to physically handicapped children might be considered as both direct and indirect. Psychological and psychiatric advice should be available, and full use made of the psychiatric social worker's skill in helping parents. This latter service seems particularly necessary when adolescents are returning home after years in a hospital or a residential school. An indirect approach would be the inclusion, in specialist training courses of all workers concerned, of a thorough study of the emotional development of normal children.

Turning to the integration of psychological services into the educational provisions for normal children, one has to select from an enormous wealth of thought, experiment and controversy. The huge and somewhat vexed question of selection for the various types of secondary education is beyond both my technical knowledge and skill and the time at my disposal. But I should like to isolate one thread and relate it to Dr. Bowlby's remark on the need for regarding a school as a community. School records are intended to ensure better educational guidance which in its turn means better adjustment to school and its opportunities. Their function is to present so good a cumulative picture of a child's development that, among other uses, reliable prognosis may be made from it. Objective tests, used judiciously, supply some of the data but not all. Assessments of personality still depend on the variety of activity the school allows and on the teacher's conception of what is "good"; that is, what will promote maximum all-round development. Unless schools, particularly primary schools, are active communities rather than cram-shops, the most cunningly devised record card is sterile and even hypocritical. How can

those challenging questions about children's initiative, interests and social development be answered unless the teacher has seen—and felt—these qualities in action? Moreover, conditions which demand a passive receptivity during the most active period of a child's life seem also to encourage over-valuation of passive "goodness". The child who refuses to be bored, but who is energetic when his activity is allowed to be purposeful, may loom as a problem child in a school where only one kind of goodness is recognised. Only as schools become active communities can children's development be assessed with anything like accuracy and justice.

The idea of a school as an active community depends on our appreciation of what is normal, at the various stages of development. (And, of course, on smaller classes in which to allow and observe activities!) The files of the educational press during the last two decades would, I think, if viewed collectively present a curious richness and an equally interesting poverty of thought and project. Throughout the first part of this period, articles on Infant and Nursery School organisation and outlook were many in number and rich in quality. During the latter half, statements and discussions on the secondary modern school have been as many and generous as the beautiful plans and photographs of modern secondary school buildings. But comparatively so little, so very little about the primary school! One of the many virtues of the new Education Act is, I think, the impetus it has given to all of us to rethink what we mean by primary school education. The whole knotty problem of selection at the end of the primary school provides an unexpected opportunity to reconsider what children ought to do from 7 to 11, and how we ought to record and assess it.

We have tried to suggest that the integration of psychological services under the 1944 Education Act can be regarded in two ways. First, it means administrative dovetailing and co-operation. Whether the Child Guidance Service is under the Education or the Health Department in any area, whatever the professional label of the head of the Clinic, psychological services for children need to include clinical treatment for those who are mentally ill, facilities for educational guidance of groups and individuals, and opportunities for preventive work. The present shortage of trained workers in all these fields makes the setting up of such a comprehensive service a matter of depressingly slow development. The appointment of untrained or partially trained workers, though it "gets something going" immediately, distorts the service and, in the long run, brings it into disrepute. The practice of seconding workers with recognised basic qualifications for specialised courses of training in Child Guidance or the various types of welfare work, merits full consideration. Such

training is often worth the temporary inconvenience of carrying on with reduced staffs.

The second aspect of the integration of psychological services is the acceptance, extension and application of whatever knowledge is available on child development and care from birth to maturity. I have tried to indicate briefly the need to apply such knowledge to certain specific problems: advice to parents of young children; the provisions for the educationally subnormal; the care and understanding of the physically handicapped; and, very briefly, to the activities and records of the primary school.

But this smiling prospect may be the grin on the face of the Cheshire cat unless one adds a word about some of those who might be used during this interim period.

The last impression I want to give is that men and women with psychiatric or psychological qualifications and experience, are the sole repositories of wisdom or necessarily of wisdom at all. But I do want to support most strongly Dr. Bowlby's plea that workers with psychological training should be used in the wider educational spheres where their insight into the causes and treatment of maladjustment would be useful in indicating preventive measures. And those allowed to do so will benefit at least as much, probably more, than those who may listen or call on them for advice. For only by seeing our advice put into practice by experts in other spheres, including the home, and only by hearing criticism of our theories and practice, are psychiatric social workers brought away from their typewriters, psychologists out of their alleged armchairs and psychiatrists out of their consulting rooms, and kept human.

The Chairman: I should like to support what Miss Gibbs has said about the Primary Schools as that age is, I think, the most formative and important of all. In the general talk on Secondary Education for all, I hope we shall not forget the Primary Schools.

We have before us a very interesting discussion and I am now going to ask Lord Feversham to take the chair.

The Rt. Hon. The Earl of Feversham (Chairman): I know I express on your behalf how very sorry we are that Mr. Butler, the scheduled chairman, has to leave in the middle of this session.

I would like at this stage of the proceedings to ask you to join with me in expressing our very great appreciation to Miss de Vere Hunt, the Organising Conference Secretary, for the arrangements she has made on our behalf during

these two days. To me, personally, it is most gratifying to come to a conference organised by this Association, attended by so many delegates from all parts of these isles. Owing to the circumstances of the war, I have been dissociated since the summer of 1939 with any of the problems or matters which have been germane to this Conference and so I come afresh, since the date of the publication of the report which bore my name in 1939, to hear your deliberations and to find so many qualified men and women interested in all aspects of the problem of Mental Health joining in a conference of this character. I would take this opportunity to say that that has been an aspect of this conference largely due to the administrative ability of the Conference Secretary, and would ask you to express to her our very grateful thanks for the arrangements she has made so well.

I will now ask Dr. Frank Bodman to initiate the discussion on Miss Gibbs's paper.

DISCUSSION

Dr. Frank Bodman (Pyschiatrist, Somerset County Council): I think this discussion is relevant at the moment, because this country is facing the implementation of the policy of full employment, and immediately we consider such a policy we are faced with the question of man power and it is brought to our notice, particularly as far as the entry of juveniles into the field of work is concerned, that the numbers are already showing signs of dwindling, largely due to the fall of the birth rate after the last war but one. We are also, of course, faced with shortage of man power if Mr. Butler's Act is implemented, because of the raising of the school leaving age.

It is very important, therefore, that we should make the very best use of our man power resources and it is, I think, reassuring to note that we have in the people of the British Isles probably very large untapped reserves of skill and of intellect which perhaps have not been mobilised to the full in the past, but it is now a very important question that we should mobilise those potential capacities, those potential skills to the very utmost. At a time when we are faced with a reduction in quantity, we must make certain that we have an increase in quality—so that we are faced with the problem of ascertainment.

I may perhaps be allowed to give a little illustration of the kind of work that is involved in this problem of ascertainment. For about seven years I worked among children in an urban population and there, perhaps as our interests were

more particularly in the ascertainment of intelligence with a view to the direction of suitable children into secondary schools, great stress was naturally laid on what we might call academic attainments; but in the past three or four years I have been working in a rural area, and one finds that one is dealing with perhaps a rather different type of human material and that the children have not the same interests and outlook as you would find in the urban child. In the urban child you may find a child of eleven years who has the mental age of a child of fourteen, as ascertained by the ordinary intelligence tests. You would have thought that such a child would qualify for a scholarship for the secondary school or grammar school; but it has been quite a frequent finding among the rural population that a child of eleven years of age who, on the ordinary intelligence test, does not show a mental age of higher than eleven years on purely academic work, yet shews the skill of a child of fourteen when on carpentry or on performance tests. It is most important that these children who have qualifications of craftsmanship should be directed into the right kind of technical school. I give this as an illustration of some of the necessary integration referred to by Miss Gibbs in her plea for the co-operation of psychologists and psychiatrists in making plans outside the Child Guidance clinics for the various educational fields.

Mr. Butler's Act has provided us with a very solid, very firm, and very wide foundation on which to build educational services and the next step, of course, is the implementation that Act requires.

You, as councillors and executive officers of the various local education committees, will be concerned in the preparation of the various schemes for your different County Councils and County Boroughs. I would reinforce the plea that in the preparation of this scheme the old inter-departmental rivalries and jealousies should if possible be overcome; and furthermore that there should be consultation with the workers in the field. I know that it is customary to describe them as experts and I would not like to claim that the psychiatrist or psychologist workers should be considered as experts—they are workers in the field and you, as executive officers and councillors, are the management; but we have seen in the past, during the war effort, the value of working parties, joint production committees, where workers and management got together. I feel that it is very important too that the workers in the field should be consulted by the management, not because they are experts but because they will have to have their share in the implementation of these Acts.

I am sure that many of you, faced with the preparation of the scheme, must be only too well aware of the great difficulties ahead of you in implementing the scheme that is to make the Act a real and live institution. You are faced with shortages of personnel. You are faced with shortage of premises, with the difficulty of obtaining properties for setting up new schools, new residential schools, new special schools, and you are also faced with the shortage of properly trained personnel to staff these special schools and special boarding schools, but I do hope that you will not be deterred by these obstacles and difficulties that are before you.

Miss H. Parker, B.Sc. (Headmistress, Victoria Secondary Modern (Girls) School, Watford): As a member of the teaching profession, may I say I feel very much at home, because a good teacher, and any Head Teacher, feels in part psychologist, part nurse, part dietician, part child guider, and a good many other things as well. I think if there is any member of the community who is aware of what is needed in the field of work with children, it is the practising teacher.

With the main points made by our two speakers I agree most heartily. If there is any one I would emphasise it is that of some kind of integration of all the services dealing with children. I know there is a shortage of personnel. I know buildings are appalling. I know that some Child Guidance clinics are housed in buildings nearly as bad as some school buildings, but I am sure there is an appalling wastage of man power in this work and we are not doing to the best advantage the thing we have been trained to do.

When I was travelling here to-day I was reminded of a story. One of my staff taking a Mothercraft revision lesson noticed one of the girls taking no part in the discussion but sitting glumly at the back of the room. She said to her, "What is the matter with you? What would you do in this case if this was your baby?" She said firmly, "If I had a child, Miss, I would wring its blasted neck." You can see what was behind that bitter remark. There was family disturbance and ill-health. Included in the number of people dealing with that child—who had many brothers and sisters—were policemen who knew them very well and who said there was not a bit of good in this particular child. There were also the Probation Officer and a Juvenile Magistrate who was a member of the School Welfare Committee; there was a District Nurse going into the home as well as the Health Visitor, the School Attendance Officer, the Welfare Officer and the N.S.P.C.C. You can count how many

people were involved. Yet in effect practically nothing was done to avert disaster, as these people working in isolation could not bring appropriate action to save the children.

I had another case a short time ago of a child who was ill. We tried to get her into a convalescent home. We could not do it through the local Health Service as no accommodation could be found for her. The child's Sunday School teacher, however, not only found a place for her but paid for a fortnight's treatment. It was not enough, of course. The Welfare Officer, the School Medical Officer, and various other persons went on trying and six months later accommodation was found. Unfortunately or otherwise, whichever way you look at it, the child was still sufficiently ill to be able to take advantage of it. This is a most unsatisfactory position from everybody's point of view.

Perhaps you have heard of the remark made by an overseas visitor to this country, "You know, when the last trumpet sounds no Britisher will ever hear it, they will all be far too busy behind Committee room doors." I feel that outside those committee room doors there is a long line of children. Probably some of them will hear the last trumpet before we come out.

As a member of the teaching profession who at some time or other contacts all Services helping children, I ask you to see first that some co-ordinating body is set up in every area so that things can be done while the child is still a child. Secondly, I would ask that we put aside all our personal feelings of preference as to which authority or which committee, or which Welfare Officer does the job. Instead of twelve people visiting the home and reporting "Mother works all day, father all night, there are children to look after and the eldest child has to stay at home," etc., we may start to pool our knowledge as soon as we know there is trouble. Then all the bodies concerned in Child Welfare can get together quickly and get on with the job.

Dr. A. A. E. Newth (Senior School Medical Officer, City of Nottingham Education Committee): I was very interested to see the sub-title of the subject for this afternoon, because we did establish in Nottingham a Child Guidance Clinic Centre under the Education Authority which we had been working towards for a number of years.

I would like to support Dr. Bowlby's view that the Education Authority has every chance. The Education Authority has the workers always going to the school—the educational psychologist, the speech therapist, the educational therapist,

the school doctor, the school nurse, and health visitors are all in close contact with the person who above all can help us, namely, the teacher. In my opinion there is one important weakness in the Education Act—although we are allowed the ascertainment of handicapped children from two years upwards, we have no authority for treating them until they are on the rolls of maintained schools.

Major Richard A. Lamb (Cumberland County Council): I am here as a Member of a County Council, and it is the County Councillors who are now faced with the task of making very difficult decisions when they try to implement their responsibilities under the new 1944 Education Act. We had these responsibilities under the old 1921 Education Act but, in many areas, they were not properly carried out. The County Council of which I am a member has decided that we must within the next few weeks make some decision as to how we are to discharge the responsibility we have to the educationally subnormal children in our area. We propose to put this matter under the Education Committee, and I am glad that the last speaker and Dr. Bowlby are convinced that our decision is right. But we are faced with some very difficult problems and I want to put them to this audience in the hope that some of the knowledgeable people here will be able to give some information which will be of use to us and other Local Authorities similarly affected.

Firstly, if we do set up Child Guidance clinics under the Education Committee, is this to be a part of the School M.O.H.'s department, or will they take their instructions direct from the Education Committee? Then, is it necessary to have a full-time psychiatrist for each Education Authority? I should have thought that the sensible solution would be that in each Regional Health Service there should be one psychiatrist who was specialised in the treatment of children and accustomed to dealing with cases brought to him by the Child Guidance clinic of the Education Committee. To my mind, that is more sensible than each Education Committee appointing its own psychiatrist, or going to the alternative of employing a psychiatrist who is already in private practice in the district. If we could have some opinion on that, it would be helpful to people on local Education Authorities faced with this question.

There is another point which I think is urgent, namely, the question of the supply of teachers trained to undertake special classes in Day Schools for subnormal children. It is all very well for us to talk about the necessity for setting up classes for subnormal children, but unless we can get quali-

fied teachers it is going to do very little good. I would like to know what the supply of these teachers is, if it is likely to meet the demand, and what arrangements are being made to train them? If there are not sufficient facilities for training teachers for these special classes, it may be that County Councils could do some propaganda to see that the output is increased.

There is another point which we have to face. In the county from which I come there are large areas to be covered. Is there any difficulty in making these Child Guidance clinics mobile? That is a point that so far we have not been able to get really clear. Does it make a difference to their efficiency if the psychiatrist, psychologist and social worker have to travel fifty miles, or must they have elaborate buildings?

Miss Norah Gibbs, M.A.: I will leave the first two questions and try to answer the third.

Before the war the then Board of Education ran, or sponsored, certain courses for teachers on the education of sub-normal children. There were regular elementary and advanced courses, both of nine weeks. In addition, Local Authorities ran weekly lecture courses for teachers. (The Central Association for Mental Welfare, one of the constituent bodies of the National Association for Mental Health, was frequently asked to supply lecturers for both types of course).

After lapsing during the war, the Ministry's courses have now begun again. One was held this summer. It is indicative of the concern of teachers that only about one in five teachers who applied for admission to that course could be accommodated. Further courses are planned by the Ministry as well as by Local Authorities and Teachers' Associations.

The greatest difficulties at present are the seconding of teachers for the courses and the scarcity of boarding accommodation. We hope that, when the present Emergency Training Colleges have vacated their buildings and when the wastage in the ranks of the teaching profession is repaired, the next priority will be properly organised courses of reasonable length and reasonable content on the education of sub-normal children, using perhaps the buildings which are now used for emergency training. (These remarks apply, of course, to arrangements in England only; Scotland makes its own).

Dr. John Bowlby: I have been asked to answer Major Lamb's question regarding Child Psychiatrists. I think it is

very difficult, perhaps a little awkward, for me, a child psychiatrist, to say how valuable my profession is, but the National Association for Mental Health in a recent report which was based on Dr. C. P. Blacker's Report suggested that there should be a child psychiatrist to every community of 120,000 population. That means about 30,000 children. If every such local area clamoured for a child psychiatrist there would not be enough to go round. I was interested in Major Lamb's proposal that, if there were not sufficient teachers for backward children, then Local Authorities might take the initiative in giving the training. At the present time the Ministry of Education take no responsibility for training child psychiatrists, Universities take exceedingly limited responsibility, and I think that if the Local Authorities are to get the personnel they want they must put their hands into their own pockets.

Miss S. Clement Brown, B.A. (late Tutor, Mental Health Course, London School of Economics and Political Science): Dr. Bowlby reminded us that Child Guidance Clinics were started as a preventive service. This is important, but even the idea of prevention may come to set unduly narrow limits to our purposes. If, for example, we are too much influenced by the idea of preventing delinquency we may concentrate unduly on the children who are a nuisance to adults. Or, if we work too single-mindedly towards the prevention of mental illness, we may miss some of the handicaps in child development which are more readily eased. Helen Witmer, in her most valuable book, "Psychiatric Clinics for Children," has pointed out the danger of allowing the Child Guidance services to become too closely identified with institutions serving other purposes in the community, so that we select only the difficulties defined for us by those institutions. Perhaps we are too much troubled by the children who are a nuisance. Some children may not be nuisances enough. In its wider aspects our service should be concerned with the growth of normal vigorous individuals who are prepared to take their share in adjusting society to the needs of citizens as well as adapting themselves to the ordinary demands of society. At the present time there exist in our society many conditions which tend towards the impoverishment of personality and character. Miss Gibbs drew our attention to the fact that adults often aim at producing *convenient* behaviour in children. Convenient behaviour, sometimes held to be the same as "good" behaviour, is not necessarily the sign of a robust personality.

A contrast has been drawn at this Conference between

the Dorothy Sayers detective school of thought, searching, so to speak, for victims, and the Beatrice Webb school, trying to reach a better understanding of the individual in the society in which he lives. My own interest in the Beatrice Webb school has taken me back to a study of the evidence of the Poor Law Commission of 1909, and if there were time I could read you a quotation from that evidence which you would find it hard to distinguish from descriptions of some of the conditions in which children are living in the Poor Law institutions of 1946 described in the Curtis Report. I wonder, shall we, or our successors, be meeting in 1980 to continue the discussion of these conditions? If so, what will be the reason? Perhaps, if this happened, it would be partly due to the undue narrowing of our interest to children who have become "problems". We must, I think, ask ourselves where this service should be placed so that it can be used in the most constructive, creative way. The answer is, I believe, wherever human beings need us. We must guard against a definition of problems only by those who stand to gain by their prevention.

During the war many of us left behind our more organised clinical methods. It would be a tragedy if we had not gained anything of permanent value by having gone out into the highways and hedges of human experience—into evacuation areas and air-raid shelters, on the battle fronts, and later in rehabilitation centres and displaced persons camps, where we were called upon to meet all sorts of human problems as they arose.

It is fashionable now to speak of "screens" and "sieves" of selection for all purposes. Screens are all right if you are sure of what you want to take and to leave on each side of the screen. One thing of which we are certain is that the life of the child is so bound up with those most intimately related to him that we cannot understand or treat him without including these relationships. Parents must not be kept behind the screen when we select children for treatment. Parents must not be made to wait in queues behind overloaded administration. I remember a father coming to a Child Guidance Clinic complaining that his boy was going insane. This father, who proved himself to be an obsessional personality, had taken his boy to three or four out-patient clinics and had been sent away with the statement that there was nothing wrong with him. No one seemed to have recognised the fact that the father's anxiety was damaging to the boy. We need to be careful that our selection methods do not prevent this kind of problem in family relationships finding its way into our clinics and being treated.

There has been a good deal of discussion as to how our clinics should be organised in the changing public services of the future. Rationalisation is all to the good if it does not lead to too stereotyped a pattern. Child guidance needs to be intimately related to the nature of the community it is serving. We must make allowances for these living differences as we plan, keeping in mind the need to be close to family life, easy of approach by the troubled parent, available for consultation for all groups of children and for those looking after them.

One of these groups whom we have so far served very little is the 130,000 or so of children deprived of normal home life. For many of these children we ourselves, as citizens, are acting as public guardians. Sometimes we are not very good parents. Perhaps we need a little child guidance ourselves to improve our understanding and skill with children whose daily lives are sometimes a denial of all that we hold most important for vigorous development.

Finally, I think we should give more thought to the question raised so clearly by Dr. Bowlby: how can we progress in the combining of knowledge and skill with which we are trying to help children and families. Dr. Bowlby has given a lead by "coming clean" about the possessiveness which is often found in professional attitudes, even when we set out to work in teams. It seems to me that the important consideration here is not who is in charge, or even who diagnoses, or who treats. The important principle is that no one should pretend to any knowledge or skill which he or she does not possess. If there is a closed shop in child guidance, it should be a closed shop of competence. But competence cannot be based on trust. It must be guaranteed by training of a high quality, and by close integration between the professions as well as within them. We should be knowledgeable about one another's training, and should understand the implications of the scientific approach and the particular skill which belongs respectively, to psychiatry, psychology and social work. Nor must we limit our interest in one another's professional practice to those who work inside the Clinics. Our concern and respect should extend to all those who are responsible for children.

Dr. Kate Friedlander (Director of the West Sussex Child Guidance Services): Dr. Bowlby mentioned in his very interesting paper that the organisation of a Child Guidance Service has some bearing on the work which can be done within limits. To put it very shortly, I would ask from the

organisation of a particular Child Guidance Service that it would allow its workers to put their energies fully into the clinical and preventive work. I feel it might be of interest to tell you shortly about the organisation which West Sussex has decided to adopt and which, as far as we can see up till now, works very well.

The West Sussex County Council decided to appoint a Child Guidance Committee, a sub-committee of the County Council, in which representatives of the Health Department, Education Department, Public Assistance Department and Probation Committee are present. The Senior psychiatrist of the Child Guidance Service is responsible to this Committee and the Child Guidance Service works in co-operation with the other social services in the county.

We believe, from our experiences so far, that there are certain advantages in a Child Guidance Service with this independent status. For instance, everybody who works in Child Guidance agrees that co-operation with teachers, health visitors or social workers in the County is of the utmost importance. In a county, as in a family, the various employees of the County Council may feel hostile towards authority; this hostility will not be carried over to an independent Child Guidance Service. What is of even greater importance is the fact that under this arrangement the Child Guidance Service is not drawn into interdepartmental rivalries. As the Education and Health Service is represented in the Child Guidance Committee, close co-operation is possible, although the service is not under any one authority.

The Chairman: It remains for me to express to those who have given papers this afternoon the appreciation of the Conference. Also to wish those who have been present all success in the work they undertake in their particular areas for the development of Mental Health. I feel confident that this Conference has provided good ground for many of the current problems to be ventilated and discussed: but the real benefit of a conference of this character comes later, when some of the recommendations for improvement can be implemented. It is hoped that this National Association will be in many respects the pivot around which the problem of Mental Health will revolve and be solved. If our Conference to-day has given 1,000 people interested in Mental Health the opportunity of comparing difficulties and a realisation of common needs, we can rest assured that there will be a demand in the next few months for a similar conference to be held in London or elsewhere. If that is the case, by August 1948, the date provisionally arranged for the World

Congress on Mental Health, this country should be in a better position than it is to-day to give the lead on many of the problems which come within our terms of reference.

I would conclude by saying this, that in your plans for the development of Mental Health and all the aspects through which the discussion has ranged to-day, do not omit one basic point. The community does not sufficiently appreciate that in the year 1946 we, the public, are allowing men and women to marry and to bring children into the world without ever having given them the opportunity of learning about the responsibilities of parenthood. Since the industrial revolution we have specialised in every conceivable branch of life; industry, commerce, medicine, science, anything we choose to name, and we have got experts in every department of these subjects, down to the smallest detail; but, for some unknown reason, we seem to have left out the one essential fundamental factor for a better community of men and women in future generations. That is the vital importance of parents knowing much more than they do at present about the best way to bring up children. I know that there are organisations which exist to develop this important subject. Miss Parker so truly said this afternoon that there are so many social workers and health visitors visiting the same house that the influence of the mother is sometimes distracted and lost. Miss Clement Brown also implied that we should not develop too departmentally so as to lose the essential purpose of getting parents to realise how best they can understand their own children. I hope the Conference will forgive me for referring to this subject, which is not exactly within the terms of reference of the agenda; but I do feel that it is insufficiently emphasised and that amongst you there are those who can do so much in this respect in local areas. I trust that you will all have found benefit in this Conference and I would thank you for your attendance.

END OF CONFERENCE



